S. HRG. 110–1081

HEALTH BENEFITS IN THE TAX CODE: THE RIGHT INCENTIVES?

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

JULY 31, 2008

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

58–428—PDF WASHINGTON : 2008

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON FINANCE

MAX BAUCUS, Montana, *Chairman*

JOHN D. ROCKEFELLER IV, West Virginia	CHUCK GRASSLEY, Iowa
KENT CONRAD, North Dakota	ORRIN G. HATCH, Utah
JEFF BINGAMAN, New Mexico	OLYMPIA J. SNOWE, Maine
JOHN F. KERRY, Massachusetts	JON KYL, Arizona
BLANCHE L. LINCOLN, Arkansas	GORDON SMITH, Oregon
RON WYDEN, Oregon	JIM BUNNING, Kentucky
CHARLES E. SCHUMER, New York	MIKE CRAPO, Idaho
DEBBIE STABENOW, Michigan	PAT ROBERTS, Kansas
MARIA CANTWELL, Washington	JOHN ENSIGN, Nevada
KEN SALAZAR, Colorado	JOHN E. SUNUNU, New Hampshire

RUSSELL SULLIVAN, *Staff Director*
KOLAN DAVIS, *Republican Staff Director and Chief Counsel*

CONTENTS

OPENING STATEMENTS

	Page
Baucus, Hon. Max, a U.S. Senator from Montana, chairman, Committee on Finance	1
Grassley, Hon. Chuck, a U.S. Senator from Iowa	2

WITNESSES

Kleinbard, Edward, Chief of Staff, Joint Committee on Taxation, Washington, DC	4
Gruber, Jonathan, Ph.D., associate head, Department of Economics, Massachusetts Institute of Technology, Cambridge, MA	6
Baicker, Katherine, Ph.D., professor of health economics, Department of Health Policy and Management, Harvard School of Public Health, Boston, MA	9

ALPHABETICAL LISTING AND APPENDIX MATERIAL

Baicker, Katherine, Ph.D.:	
Testimony	9
Prepared statement	29
Baucus, Hon. Max:	
Opening statement	1
Grassley, Hon. Chuck:	
Opening statement	2
Prepared statement	35
Gruber, Jonathan, Ph.D.:	
Testimony	6
Prepared statement	37
Kleinbard, Edward:	
Testimony	4
Prepared statement	39

COMMUNICATIONS

Business Coalition for Benefits Tax Equity	47
Center for Policy Analysis and Rekindling Reform	52
Employee Benefit Research Institute (EBRI)	55
National Association of Health Underwriters	62
National Business Group on Health	76
National Federation of Independent Business (NFIB)	83

HEALTH BENEFITS IN THE TAX CODE: THE RIGHT INCENTIVES?

THURSDAY, JULY 31, 2008

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:05 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Lincoln, Wyden, Stabenow, Salazar, and Grassley.

Also present: Democratic Staff: Bill Dauster, Deputy Staff Director and General Counsel; Elizabeth Fowler, Senior Counsel to the Chairman and Chief Health Counsel; Cathy Koch, Senior Advisor, Tax and Economics; Shawn Bishop, Professional Staff Member; Neleen Eisinger, Professional Staff Member; and Bridget Mallon, Detailee. Republican Staff: Mark Hayes, Health Policy Director and Chief Health Counsel; Christopher Condeluci, Tax and Benefits Counsel.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will come to order.

The Yale literature professor Peter Brooks once wrote: "We live immersed in narrative, recounting our past actions, anticipating our future projects, situating ourselves at the intersection of several stories not yet completed."

Here in this committee we have lived immersed in separate narratives, anticipating health care reform and tax reform. Today we situate ourselves at the intersection of these two stories not yet completed.

Today, we focus on tax subsidies for health benefits. As our health care and tax reform narrative progresses, I expect that we will be hearing more and more about this particular story. The tax code includes many provisions that affect health care: FSAs, HSAs, the TAA Health Coverage Tax Credit, and the deduction for medical expenses in excess of 7.5 percent of AGI, a virtual alphabet soup of provisions.

But the tax subsidy most relevant to today's hearing is a provision that one of our witnesses has called "the third largest government entitlement for health care," that is, the exclusion of employer-sponsored health benefits from individual taxation.

One hundred and sixty million Americans, three-fifths of the non-Medicare population, receive health benefits through the work-

place. The tax code does not count the cost of this health insurance coverage as income, and as a result the Federal Government receives about $200 billion less revenue each year.

Economists have long recognized that the tax exclusion for health benefits is regressive. In 2004, nearly 27 percent of these tax expenditures accrued to families with annual incomes above $100,000, although this group accounted for only 14 percent of the population.

At the other end of the scale, only 28 percent of these tax expenditures went to families with incomes below $50,000, although this group represented nearly 58 percent of households.

Not only do higher-income families receive more benefits due to their marginal tax rate, but they are also more likely to receive health care benefits from their employer. Economists also tell us that the tax treatment of employer-sponsored health benefits creates an incentive for over-insurance, and they tell us that this incentive, in turn, promotes health care cost inflation.

The current system is a result of evolution dating back to World War II. We have the system that we do by chance, not by design. If we were designing a health system today, we would do things differently.

That said, we have also learned, from past attempts at health care reform, that too much disruption can backfire, too much change for those who already have health coverage can cause a backlash, and since the majority of Americans get their health care coverage through their employer, any changes to the current tax subsidy should be done carefully and deliberately.

We need to have a full understanding of the advantages, disadvantages, and consequences. Some have proposed transforming the current system into a system where individuals need to purchase their own insurance and employers no longer have a role. That would be no trivial matter. That might be too much change.

All of us here recognize that our system is unsustainable. We cannot continue on our current path, but we must strike a balance. We need to fix what is broken without breaking what is working. Thus, tax subsidies for health care stand at the intersection of health care and tax reform. As we anticipate our future projects, let us think about what role these provisions will play in our unfolding narratives. Let us consider ways to change the system as much as appropriate, but not more so. Let us try to find a happy ending for our several stories not yet completed.*

Senator Grassley?

OPENING STATEMENT OF HON. CHUCK GRASSLEY, A U.S. SENATOR FROM IOWA

Senator GRASSLEY. Yes. First of all, I will apologize to the audience and to our witnesses, because I may go down the hall to participate in a Judiciary Committee meeting just as soon as they get a quorum, so I may have to submit questions—and I have a lot of questions—for response in writing if I do not get back.

---

*For more information, *see also,* "Tax Expenditures for Health Care," Joint Committee on Taxation staff report, July 30, 2008 (JCX–66–08), *http://www.jct.gov/publications.html?func=startdown&id=1273.*

I commend Chairman Baucus for holding this hearing. It is a continued examination of our health care system, and one that needs to be examined. I would also acknowledge how much I appreciate this hearing because the tax treatment of health insurance has kind of been an elephant in the room that nobody wanted to talk about.

The most commonly recognized things we talk about with government and health care are Medicare, Medicaid, and SCHIP. We often overlook the Federal subsidy program for health care that is run through the tax code, and the tax code subsidizes private health care spending. The Congressional Budget Office has estimated that 55 percent of our Nation's health care spending is made up of private health care spending, and this means that the rest of it, the 45 percent, is the government programs I just mentioned.

So while Congress has entered into long and often pointed debates on how we can slow the growth of public health care spending, we have not fully debated the growth of private health care spending. If efforts are not taken to slow that growth, both public and private, we are told that by 2025 it is going to take up 25 percent of our economy, and that could easily be 50 percent another 60 years down the road.

So I am glad we are doing here what needs to be done. We are taking a first step towards recognizing this elephant I've referred to. That is, we are all coming together to examine the third largest Federal subsidy program for health care, the tax code.

Before we begin our examination, it is important for people to understand—that employers, unions, and the public at large understand—what the current tax rules are. We all have to understand how they work, and most importantly, how they are going to affect economic behavior.

There are three important points. First, many economists argue that preferred tax treatment gives people an incentive to overinsure. In the current tax treatment of health insurance, if it makes people exercise and use the health system more often, we need to understand what changes in our tax rules might affect that. I will bet that if you ask the American public whether they want more affordable health insurance, they want Congress to fix the rules.

Second, based on economic evidence, it is clear that the employer contributions towards an employee health insurance are not provided as a gift; rather, it is part of the package, and we need to understand how people feel about that as part of their wage package, whether or not they want more disposable income or they want it through their health care plan.

Then, third, we need to look at the current tax treatment of health insurance, if it is inequitable from the standpoint that it is more of a benefit to higher-taxed people than lower-income people. So these are the questions we have to look at at this hearing.

I would like to put my entire statement in the record, Mr. Chairman.

The CHAIRMAN. Without objection. Thank you very much, Senator.

[The prepared statement of Senator Grassley appears in the appendix.]

The CHAIRMAN. I thank all of our witnesses for coming to the hearing today. This is very important. It is kind of, I think, at the heart, or one of the hearts, of health care reform. I thank you very much for your efforts.

Our first witness is the Chief of Staff of the Joint Committee on Taxation, Ed Kleinbard. Next, we have Jonathan Gruber, professor of economics at the Massachusetts Institute of Technology. Dr. Gruber helped to design the Massachusetts health reform plan and served on the board of the State's Insurance Connector implementing body for the health reform effort. The third witness is Katherine Baicker, professor of health economics at Harvard. From 2005 to 2007, Dr. Baicker served on the President's Council of Economic Advisors. Thanks, all, for taking the time. We deeply appreciate it, and I urge you to just let 'er rip. Do not pull any punches. Tell us what you think.

Mr. Kleinbard?

STATEMENT OF EDWARD KLEINBARD, CHIEF OF STAFF, JOINT COMMITTEE ON TAXATION, WASHINGTON, DC

Mr. KLEINBARD. Thank you, Mr. Chairman and members of the committee.

I would like to use my time with you this morning to review how we use the tax code to deliver Federal subsidies for health care and why this choice of a subsidy delivery system has important consequences, both for health care and for tax policy.

Let us begin with a chart that my staff has prepared showing the sources of insurance coverage for Americans under age 65. To me, there are several remarkable lessons to draw from this chart. First, of course, is the critical problem of 44 million Americans who have no health insurance at all. You can see them in the top left of the pie chart before you.

Second is that almost all Americans who do have health insurance obtain that insurance with the help of Federal subsidies. Only about 8 million Americans acquire insurance without any form of Federal assistance, and they are the group labeled "non-group" down in the bottom left there.

The third point that I draw from this chart is that Federal subsidies come in two basic flavors. There are direct subsidies like Medicare and SCHIP, and there are indirect subsidies that we deliver through the tax system.

Finally, what I infer from this chart is that by far the largest number of Americans who do have health insurance obtain it through an employer-sponsored insurance in which Federal subsidies are delivered through the tax system.

Let us now focus on those subsidies that, in fact, we deliver through the tax system. Perhaps we could have the next chart, if you do not mind. Again, my staff has prepared a chart that summarizes the situation. What this chart does is summarize the dollar value of the annual Federal subsidies for health care that we deliver to Americans through the tax code rather than directly by writing out the checks or providing medical services to them.

Here again, we can see when we look at these Federal health care subsidies delivered through the tax system that employer-sponsored insurance is by far the most important component. Not

only is that Federal subsidy running at the rate of $245 billion a year, but it is coming from both our general Treasury funds—that is, from general tax revenues—and from reductions in trust fund collections.

I would also like to point out that the technical term for what I am trying to describe here, that is, the idea of Federal subsidies delivered through the tax code, is what tax policy professionals call a tax expenditure. It has been a theme of the Joint Committee for the last year to try to emphasize the relevance of tax expenditure analysis in looking at tax policy questions.

So what do we draw from these two charts? We conclude that employer-sponsored insurance dominates the health care picture, both in terms of the numbers of covered Americans and in terms of the number of dollars spent by the Federal Government.

The mechanism by which we use the tax code to deliver subsidies for employer-sponsored insurance is very simple, as the chairman has already described. Employers can deduct the cost of the insurance that they buy for their employees, but employees do not have to include this particular form of compensation in their income. The result is a favorably asymmetrical tax regime. There is substantial evidence that this favorable tax environment explains why employer-sponsored insurance dominates the health care coverage picture.

Now, having said that, the question is, is that a good or a bad place for this country to be? Well, it turns out that employer-sponsored insurance has some very powerful non-tax advantages. Employer-sponsored plans are group plans, and there are some very powerful advantages to group plans.

The group deals with the issue of adverse selection, the fundamental problem that, if everybody buys insurance individually, those who need insurance the most are the first in line, and therefore those who are young and healthy tend not to buy into the system.

The group has superior negotiating power with an insurer than a single consumer might, and the group can achieve significant administrative savings. So these are powerful advantages of employer-sponsored insurance, or any other group insurance plans.

Having said that, then what is wrong with employer-sponsored insurance? That is, once we have decided that the Federal Government will subsidize health care, why not deliver the Federal subsidy through the tax incentives, just as we do today?

I think there are three clusters of issues for this committee to consider in this respect. The first is that employer-sponsored insurance, or any other tax expenditure, distorts our picture of the government, and it distorts the economy. It distorts the apparent size of our budget in our government by making the official Federal budget and the overall size of government look smaller than they really are, because the foregone revenues, the $250 billion that we do not collect every year from employer-sponsored insurance, does not appear in our budget as an inflow followed by an outflow. It simply is not there at all. That is also true of every other form of targeted tax relief, that is, every tax expenditure.

Employer-sponsored insurance plans also distort taxpayer behavior, as the other witnesses will, I believe, develop in detail. These

have important economic costs. It is not merely an inconvenience, but adds economic costs. It reduces the welfare of the American citizens.

Second, employer-sponsored insurance, as currently constructed, means the government cannot control its own subsidy. There is no cap on the value of the employer-sponsored plans, and there are very few limitations on the design of the plans. So it is employers and employees collectively, not the Federal Government, that define how much Federal spending there will be in this area.

The subsidy also, as the chairman has pointed out, varies with the tax brackets of the employees. This is sometimes known as the upside-down subsidy problem, where people in higher brackets get a larger subsidy than people in lower tax brackets. Of course, this also means that the amount of the Federal subsidy will change every time tax rates for individuals change.

Finally, the third cluster of issues to consider is that the subsidy is not universally available. Everyone pays indirectly for the subsidy for employer-sponsored insurance in the form of higher tax rates to fund the $245 billion a year in implicit subsidy payments, but the subsidy is not available to everyone.

It is not available to employees of employers who do not offer plans, it is not available to part-time employees, and so on. So, only employees of employers that offer these plans can obtain the subsidy. We should contrast that with the classic medical expense deduction which, if you are unfortunate enough to have very high medical expenses relative to your income, at least is universally available.

And, finally, what follows from the fact that this subsidy is not universally available is, in addition to the question of fairness that we all pay for something that not all of us can obtain, we have the phenomenon of job lock in which employees, in effect, stick with jobs and careers they do not necessarily want simply in order to preserve the employer-sponsored insurance that they have.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Mr. Kleinbard.

[The prepared statement of Mr. Kleinbard appears in the appendix.]

The CHAIRMAN. Dr. Gruber, please.

STATEMENT OF JONATHAN GRUBER, Ph.D., ASSOCIATE HEAD, DEPARTMENT OF ECONOMICS, MASSACHUSETTS INSTITUTE OF TECHNOLOGY, CAMBRIDGE, MA

Dr. GRUBER. Thank you very much, Mr. Chairman and the committee, for allowing me to testify today.

What I would like to do today is to cover three things in my testimony. I would like to briefly discuss the existing treatment of employer-sponsored insurance, or ESI, by the tax code; I would like to review the problems caused by that treatment; and I would like to discuss complementary policies that can blunt the effects of changing this tax treatment.

As both Senator Baucus and Senator Grassley mentioned, the tax exclusion of employer-sponsored health insurance expenditures from the income and payroll tax is the third largest government health program in America after Medicare and Medicaid at a cost

of over $250 billion a year. It is important to remember that this is a tax break to individuals, not to firms. So, when MIT pays me in cash wages, I am taxed on those wages. When MIT pays me in health insurance—MIT spent about $10,000 this year on my health insurance—I am not taxed on that. That is a $4,000 tax break to me.

To be clear, it is not a tax break to the firm. MIT is indifferent whether they pay me in health insurance or in wages; either way, they deduct that from their expenses. It is a tax break to the individual, to me, in the amount of about $4,000 a year.

Now, this tax exclusion has three important problems with it. The first is, $250 billion a year is an enormous sum of money that might be devoted much more effectively to addressing the needs of U.S. citizens. Second, this is a regressive entitlement, as has been mentioned, with more of the benefits going to the upper half of the income distribution. Finally, this tax subsidy makes health insurance artificially cheap because it is bought with tax-sheltered dollars as compared to other goods which are bought with after-tax dollars, leading to over-insurance for most Americans. As a result of these limitations, no health expert in America today would ever set up a health system the way that we have it set up.

Now, that is different from saying that we should just remove it, we should remove the tax exclusion. Technically, it would not be that hard to remove the tax exclusion. Employers could declare on your W-2 what they spent on health insurance, you would then be taxed on that as if it was wage income. However, the problem is that our existing system is predicated on this tax bribe. The reason that the majority of people get their health insurance through their employer is because of this tax bribe, and so just pulling that out will cause severe dislocation.

Now, there are two reasons why this might be considered a problem by yourselves, and I am here to tell you one reason is wrong and one reason is right. The wrong reason to care about employers leaving the system is that we might lose employer dollars providing health insurance. Both economic theory and economic evidence is clear on this: there are no employer dollars. It is the employee dollars that are at stake here. If employees get health insurance, they get less in wages.

So, if employers drop out of providing health insurance, over a period of years they will make that up by paying higher wages to their employees. So the issue is not, we often hear the term about "keeping employers in the game" or "shared responsibility." It is important to remember, those are political notions, not economic notions. If employers stop offering health insurance, that will just be shifted to other forms of compensation. That is not going to ultimately affect the employer's bottom-line obligation. That is the wrong reason to worry.

The right reason to worry is that the erosion of employer-sponsored insurance will cause sicker and older individuals to move from a system, as Mr. Kleinbard mentioned, where they are pooled and fairly priced to one where they are not. The existing non-group insurance market in America is a disaster today in most States. Sicker and older people can be excluded from insurance altogether, they can be charged many multiples of healthier people, or they

can be charged a low price when they are healthy and then dropped when they get sick. That is not the way insurance is supposed to work. The problem with an erosion in employer-sponsored insurance is that these sicker and older individuals could end up facing a very harsh environment if they are dropped by their employers.

So what I want to do is conclude, then, with four directions we might go to deal with reforming this enormous tax subsidy. The first is to remove the exclusion either slowly or partially. So, for example, as a way of phasing this in, President Bush's tax panel, in 2005, recommended capping the exclusion at the average level of health insurance premiums and then tying that cap to the CPI, not health care inflation, so it would essentially slowly erode over time.

Alternatively, we could tax individuals on a part of their tax exclusion, not take away all of it. There are a number of options, and I would be happy to discuss them further, for sort of phasing into getting rid of this tax exclusion.

The second would be to reform the outside market so that individuals have better options should they lose their employer-sponsored insurance, in particular, reforming the ability of insurers to charge excessive prices to sicker and older individuals. Of course, this reform cannot happen in a vacuum, because if it did that could lead to a large rise in prices in the non-group market.

That leads to my third suggestion, which is a complementary policy with mandates on individuals to buy health insurance. As was shown in my home State of Massachusetts, such a mandate can lead to low prices for non-group insurance with broad health insurance coverage. Moreover, one of the most striking findings from our early analysis of the Massachusetts plan is that we have raised employer-sponsored insurance coverage in Massachusetts, not lowered it.

Employer-sponsored insurance in Massachusetts is up almost 100,000 people, despite falling in every other State in the Nation, and the reason is the individual mandate. The reason is, people have gone to their employers and said, hey, I need health insurance now, and employers are offering it. So that could be a natural complement that can offset any dislocation from getting rid of the ESI exclusion.

Finally, a natural alternative is to move from subsidizing individuals to subsidizing firms. That is, rather than this implicit hidden subsidy that Mr. Kleinbard talked about, if we are really worried about employers leaving the game, then we could subsidize those employers to stay in the game. In particular, there is a clear group of firms that does not offer health insurance: small and low-wage employers. Therefore, a tax credit that is tightly targeted to small and low-wage employers can effectively promote their offering health insurance.

I just want to conclude by emphasizing this must be tightly targeted, but a tax credit that was, for example, focused on firms of less than 25 employees, where the average workers earn less than $30,000 a year, could dramatically expand health insurance coverage without actually costing a huge amount of government resources.

So I want to thank you again for allowing me to testify today, and I am happy to discuss any of these points further.

The CHAIRMAN. You bet. Thanks, Dr. Gruber.

[The prepared statement of Dr. Gruber appears in the appendix.]

The CHAIRMAN. Next, Dr. Baicker.

STATEMENT OF KATHERINE BAICKER, Ph.D., PROFESSOR OF HEALTH ECONOMICS, DEPARTMENT OF HEALTH POLICY AND MANAGEMENT, HARVARD SCHOOL OF PUBLIC HEALTH, BOSTON, MA

Dr. BAICKER. Thank you very much for the opportunity to speak with you here today and to serve with such distinguished panelists.

I agree with almost everything that has been said so far, and I will choose to elaborate a little bit on what I think are the real disadvantages of the way we are financing health insurance in the tax structure today, and some of the advantages of moving to another way of using that vast pool of resources.

As people have already mentioned, the tax structure today is both unfair and inefficient. There are not that many opportunities for reforms that would both improve the distribution and improve the efficiency with which those dollars are spent, but this is one of them.

It is unfair because the current tax advantage is only available to people who get insurance through their jobs, for the most part, and is higher for people with higher incomes and higher for people with more comprehensive benefits. I do not think anyone would stand up today and say, I would like to design a new system where the benefits go disproportionately to wealthier people with better jobs and better sources of insurance. That does seem like an upside-down subsidy.

But it is also inefficient in another way in that it promotes the type of insurance policy that encourages over-use of care of really questionable benefit. That is because the care that you consume through a policy that you get through your employer is subsidized through the tax code, being exempt from both payroll and income taxes, whereas care that you consume on your own, either because you are purchasing health care directly or because you do not have an employer policy, is usually paid with after-tax dollars.

So, if you have a choice, you would like to get an employer policy that covers as much as possible. You would like every doctor's office visit to be covered by your employer policy because it would be so much cheaper to consume a doctor's office visit that way than to have to pay for it with after-tax dollars.

That is one of the reasons that I think health insurance looks so different from other kinds of insurance that people purchase today, different from auto insurance, different from homeowners' insurance. It covers a lot of routine care that would not normally need to be insured against with very low co-payments, because that is what the tax code promotes.

Now, that is not so bad in the sense that insurance is giving people valuable financial protection from really big expenses (by having a more affordable fixed premium) that they would incur in the unfortunate case that they have ill health and need to consume a lot of health care. But, at the same time that they are getting that

financial protection, they are also being encouraged to consume care of really questionable value. This is particularly problematic in a world where there are lots of people without access to insurance and basic care of very high value.

Our system is producing under-use of basic care at the same time that it is producing over-use of care that really comes with very low health benefits. That is one of the big advantages of reforming the tax code. Not only would you be able to redistribute these $250 billion plus of resources in a way that is more equitable, but you could also use them to ensure that everyone has access to basic care, while not subsidizing an infinite amount of care for a subset of people. Every extra dollar that is spent on health care through the form of employer-provided insurance is being subsidized, while some people are then going without very necessary care.

So, what would the ideal world look like then? How could you use this pool of resources to stretch our health care dollars further? First, you could remove the incentive to get extra care on the margin. Second, you could leave in place an incentive to be insured, so, on the extensive margin of having insurance, we have a strong interest in subsidizing the purchase of at least basic coverage for everyone in society.

Why is that? Well, there is, first, the altruistic motive of caring very much about the well-being of people who cannot afford health insurance, and thus cannot afford care that they need for vital health expenses. But also there is a less altruistic motive of ensuring that care is consumed in a more efficient way. Uninsured people who go to the emergency room or who forgo preventive care that would have really high payoffs then end up imposing a lot of costs on the insured through uncompensated care at hospitals or through less efficient use of resources. So all of this means that our dollars could go further, given that we are going to help take care of people in emergency situations, if we could strongly encourage people, either with carrots like subsidies or sticks like mandates, to be insured.

Insurance markets function best when everyone is covered by them, so that is the motivation for continuing to subsidize the purchase of at least basic policies, especially for low-income people. What we do not want to do is to keep subsidizing extra care on the margin. Once people are covered by a good insurance policy, we do not want to keep using tax dollars to subsidize more, and more, and more health care consumption, especially if it has potentially very low health benefits for people.

One way you could do that is by having a flat tax benefit, a tax benefit that is the same for everyone and does not increase if you consume a more expensive health insurance policy or more health care. As Jon alluded to, there are lots of dangers of completely shredding the existing system and rolling it over immediately into a flat tax benefit, but those risks could be mitigated by complementary policies.

One of the most important sets of complementary policies that I will just mention briefly is ensuring that, when people go to the individual market to buy health insurance, their premiums will never rise if they fall sick. Insurance is not just about protecting you against high expenses today. It is also about protecting you against

the risk of falling ill and having predictably high expenses that would otherwise raise your premiums tomorrow.

We thus have a responsibility to ensure that, as we encourage people to go get health insurance through their employer or on their own, no matter where they are getting their insurance, once they have insurance they then do not face this risk of higher premiums if their costs go up because of poor health. It is particularly important, as people move from an employer market that has group rates to an individual market, that they then buy into a market that affords them that kind of protection.

I thank you again for the opportunity to speak with you and would love to answer any questions you might have.

The CHAIRMAN. Thank you all very much.

[The prepared statement of Dr. Baicker appears in the appendix.]

The CHAIRMAN. One question I have is, if there is a reasonable cap placed on the exclusion, what are some of the unanticipated consequences that are going to flow from all of that? Some are anticipated, and almost by definition you cannot enumerate the unanticipated. But what are some of the concerns? Because that is a pretty big step. Things happen. Insurance companies, employers, employees adjust. But I am trying to figure out what some of the adjustments will be, so there is some sense of what we might be doing if we were to cap, say, the exclusion.

Dr. GRUBER. I think it is hard to list what is anticipated and is unanticipated. I think it obviously depends on the level of the cap. But, if you were to cap it at a fairly high level, then I do not anticipate you would see an enormous reduction in the number of employers offering insurance and the number of employees taking it.

The CHAIRMAN. But for a cap that starts to squeeze it a little bit, then what are some of the consequences?

Dr. GRUBER. Basically, as the cap starts to squeeze, then you are going to see that employers are going to react in three ways: first, they will be less likely to offer health insurance because the fact we are bribing them is now mitigated; second, they will shift more of those costs to employees in the form of higher employee contributions; and third, they will reduce the generosity of the insurance that they buy. Employers react in all three ways.

I think what is very important to remember is, how that will play out depends very much on what you do with that money. As you are squeezing it, you are raising more money. If that money is just going to highways, then we are done and you can do what I explained. But if the money is actually going back into reforming insurance markets and other things, then that itself has feedback effects on employers. I mentioned the individual mandate. That could mitigate a lot of the effects I just talked about. So I think capping the exclusion itself would have those three main effects, but I think you have to think about what you would actually do with the money, because it would then have secondary effects as well.

The CHAIRMAN. So, all things being equal, what might you do with that extra money in the health system?

Dr. GRUBER. Well, I think basically what you would ideally like to do is a lot of what Kate mentioned, which is basically, you would like to take that money, which right now, as Mr. Kleinbard said,

is a hidden subsidy that is encouraging generous insurance. You would like to take that money, give it to individuals in a more progressive fashion.

You could do it through a flat credit, or, as we have done in Massachusetts, you could actually do a progressive subsidy system, give it to the lowest-income people to help them afford insurance, and then reform insurance markets so that, when people do actually leave this employer system, they have some place to go.

The CHAIRMAN. Yes. Do not misunderstand, but some of your answers might be in the context of the Massachusetts plan. I am just curious, apart from the Massachusetts plan, what would some of the consequences be in the rest of the country? I guess you have probably answered that question. I guess, in Massachusetts anyway, you do not have a cap. We are talking about Federal.

Dr. GRUBER. No, no. We have not touched the tax exclusion. I think the general point is, I think the general effect is, the more you squeeze the employer system, the more employers are going to react by getting out of the system.

The CHAIRMAN. Some employers stated actually that the current system is beneficial in the sense that it causes them, employers, to be much more efficient in the health care coverage they provide for their employees, namely that they are forced to have wellness plans, they are forced to have policies within the firm which encourage better health, focus on obesity, cigarette smoking, et cetera. It is because, even though they get the exclusion, it is an exclusion, not a credit. So it is beneficial for them. It helps their bottom line, the more they have healthy employees. That is another advantage I have heard some employers suggest. Do you think that is valid or invalid, anybody?

Mr. KLEINBARD. I would argue that that is not entirely valid. There is actually another hidden tax subsidy at work that we need to identify. Obviously employers want to deliver to employees the most bang for the buck, and so a plan in which you can give employees both as high a cash compensation and as good a value of insurance as possible, is a more attractive compensation package than an insurance package that you tell your employees is very expensive but is not delivering a lot of value to them. So in that sense, yes, employers are going to want to have a more attractive, leaner system. But ultimately, as Dr. Gruber says, it is the employee's money. The question is whether the employers are spending it wisely or not.

There is, however, another tax subsidy that is not often appreciated. It is not at the Federal level, it is at the State level. For large employers, there is a tax reason to prefer to self-insure. Once you self-insure, then, Mr. Chairman, all the points you make, of course, become absolutely true. Once you self-insure, then the employer, as insurer, wants to cut down on claims.

The CHAIRMAN. It is more than being self-insured.

Mr. KLEINBARD. I am sorry, sir?

The CHAIRMAN. You are right. Self-insured companies.

Mr. KLEINBARD. And the tax reason to do this is that, when employers buy insurance policies, they have to pay State insurance premium taxes. When they self-insure, they avoid the State taxes. That is a significant thing.

The CHAIRMAN. Thank you very much.

Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman. You are following through again by tackling the big issues, and I really appreciate your doing that.

We have three of the all-stars here in health care, and I have appreciated your testimony.

It seems to me, more than anything else, the unfair, out-dated Federal health care rules show how broken the health care system is. These rules are now being used so that, if you are well off, you can get a Cadillac health plan and get a Federal tax subsidy for your designer smile or your designer eyeglasses. But, if you are poor and you have no health plan, you get nothing.

So, what 16 of us here in the Senate have done, 8 Democrats and 8 Republicans, is we have said, through the Healthy Americans Act, we are going to take away the subsidies for the Cadillac health plans and use that money so that every family in America would have a progressive deduction of $15,000 annually. We think this is a trifecta. It gives the health care system more efficiency, it is fairer, and there would be a progressive way to expand coverage. I think all of you have essentially said that.

I want to start with you, Mr. Kleinbard. I have appreciated your good work. The typical family, statistics indicate, spends about $12,000 a year on health insurance. With our progressive $15,000 a year deduction, it looks to me like 80 percent of America would get a tax cut right out of the gate. Is that in the ballpark of being correct?

Mr. KLEINBARD. From memory, I think that is correct, sir.

Senator WYDEN. All right.

The second point then deals with the very important issues Senator Baucus talked about, which is this question of disruption. How do you do this so that people do not just walk away with a sense of bedlam and confusion? So what we do is, we say, anybody who wants to keep their employer package and any worker who wants to keep their employer package, they could do it.

But, if you wanted to go to a best-of-both-worlds approach, where you could be part of a group in effect, so you would have some clout, but you would have more individual control so that you could get the financial rewards of shopping, we think you ought to have that option.

Mr. Kleinbard, is that not what you and Dr. Orszag scored when you did the report for us? I am looking at the report. It says we would be budget-neutral 2 years in, and in the 3rd year we would start generating surplus. Is that not what you scored for us, something that attempts to address the best-of-both-worlds approach?

Mr. KLEINBARD. Yes, sir. What we attempted to score was your proposal, which of course you have ably summarized, as nonpartisan resources. We did not label it the best of both worlds.

Senator WYDEN. I will not stick with you having to describe it my way.

Mr. KLEINBARD. But obviously you have ably described it. I would just add as a footnote that the program that we scored has a tremendous number of details that in effect were part of the reason that we had some confidence in our numbers. An awful lot of

ideas are expressed in a very inchoate way. What you had was a 12- or 13-page term sheet that went through, with quite a high level of precision, how you would exactly deliver these benefits without the money sort of dissipating along the way. I just cannot emphasize enough the importance of thinking through those kinds of rather dull, but very important, administrative details in any new proposal.

Senator WYDEN. Fair enough. I share your view.

So then, it allows me to wrap up with the two of you, Dr. Baicker and Dr. Gruber. We are all rooting for Massachusetts. It is so important that this be successful. You all, for 25 years, have put tremendous effort into trying to tee this up.

Would something like what we are talking about not be a real opportunity for States to have some of the additional dollars, particularly by reconfiguring this tax system so that you can make the transition that you all have tried to do, which strikes me as the best-of-both-worlds kind of approach on the State level. If you do not have those dollars, it seems to me States are very strapped, both in terms of having the tools to contain costs and having some of the money for subsidies for low-income people. Would not a financing approach like this be of help?

Dr. GRUBER. Senator Wyden, I think that is an excellent point. A very wise man once said to me that States trying to reform health care on their own are like a basketball player trying to jump with cement in his shoes.

Senator WYDEN. Who was that?

Dr. GRUBER. I am not sure. I do not recall. Basically, Massachusetts was in a unique financial position. It cannot be emphasized strongly enough. We had a large Federal grant that could finance part of our reform, and we had existing taxes on providers that could finance part of our reform. We really were the most able State in the country to do this, financially.

Most other States do not have those advantages. I work very closely with Governor Schwarzenegger and the legislature in California. They clearly did not have those advantages, and ended up with an enormous price tag on their reform which just could not be met. So I agree there needs to be a major Federal effort of the kind that your bill proposes, or of other kinds, to make this possible.

I think a very interesting question you are raising is, what is the interface between the Federal Government and the States, ranging from—essentially the Federal Government gave seed money to Massachusetts to make our plan happen—ranging from the Federal Government giving that kind of seed money to other States on the less ambitious side, to your plan on the more ambitious side where States would raise resources, partly because States would get tax income now on health insurance benefits. Ed maybe has numbers on that.

But States would raise money from that as well. They would be freed up because many of their publicly insured citizens would move to private insurance. So a plan like yours would free up a lot of State resources. I think a key issue, as this committee and others work forward, is how you want to interface with the State and Federal responsibility.

The CHAIRMAN. Senator Salazar?

Senator SALAZAR. Thank you very much, Chairman Baucus, for continuing to focus on this major issue that faces our country.

My question to you, Jonathan and Kate, has to do with what the reaction would be if you take 165 million Americans and you say this "tax bribe," as you call it, Jonathan, is going to be taken away, so we are going to tax you on your $10,000 of health care, which now we are going to consider as income.

How, in the context of trying to reform a health care system, does one go out and explain to people who have been the beneficiaries of a system which now has been in place for more than a generation, for more than 50 years, how do you explain to them that what you are doing is, they may still continue to get health insurance through their employer, but now they are going to have to pay an additional—as in your case at MIT, Jonathan—$4,000 in taxes?

Dr. BAICKER. You are raising a very important point, that it matters a lot what you do with those resources that had been going to subsidizing employer-provided insurance in this particularly unfair and inefficient way that we have talked about. If you just removed it whole cloth, with no substitute and no extra help for people, there would be a lot of people who could no longer afford the policy that they had been getting through their employer, and there might be an increase in the number of uninsured people.

Alternatively, you can take that pool of resources and devote it to subsidizing health insurance purchases, but maybe in a more efficient way, in a way that is devoted more to people at the low end of the income distribution than the currently regressive subsidy that we have now, but where employers themselves are not paying any more or less in taxes depending on the mix of wages and health insurance that they give.

Most people's tax bill could go down depending on how much they had been spending on health insurance. The people whose tax bill would be most likely to go up would be the highest-income people and the people with the most expensive health insurance policies, which is not always high-income people, but is disproportionately high-income people.

If you left in place a big subsidy for the purchase of any health insurance through, say, a tax credit that could be flat, could be progressive, could be structured a lot of different ways, then a lot of people would be getting at least as much help with the purchase of health insurance as they are today, and a lot of those resources could be redirected to people who do not have health insurance today because they are not currently getting any help.

I do not think that anyone could put forward a plan where everybody's tax bill goes down and more people are insured. You have to put resources into the system to increase the number of insured people, but hopefully you can do that in a progressive way that ends up with most people better off, and the people who are paying a little bit more are the people who can most afford to do so.

Senator SALAZAR. Dr. Gruber?

Dr. GRUBER. Yes. I think what Kate said is exactly right. I think the important thing is to emphasize what she said at the end:

there is no free ride here. If we are going to cover 48 million Americans with insurance, it is going to cost money. I have estimated that we could get rid of the tax exclusion and have universal coverage in America, and have about $50 billion a year left over to play with, do other fun things with. But in a plan like that, essentially the top half of income taxpayers would be losers and the bottom would be winners, and that is very difficult to do.

So basically it is just an issue of how you transition. You raised a very important and difficult issue. If you are going to take this away—Senator Wyden said he has a plan where maybe 80 percent of people win. That is still 20 percent of people who lose. How you are going to deal with those losers, I think, is why you cannot just take this tax exclusion away in a vacuum.

Senator SALAZAR. I have 1 minute left. A question with respect to small businesses, as you described them, under 30 employees, with employees making under $30,000 a year. If you were to go after those small businesses and provide a tax credit, how would you go about doing that and how effective do you think it would be in terms of bringing those uninsured people into coverage?

Dr. GRUBER. I think it would be very effective. The main reason people do not have insurance in America is because it is not offered by their employer. Most people who are offered insurance, take it. So I think it would be very effective.

Moreover, what is nice about this is, it is a very clear subsidy that firms are not offering. All large firms offer, all high-wage firms offer. It is the small, low-wage firms that do not offer. So I think you could have a targeted credit which would be effective, and it would not at all get the majority of the 48 million, or even close to it. But it could be part of a larger package that could help address the dislocation from getting rid of the exclusion.

Senator SALAZAR. Mr. Kleinbard, on that answer, do we have any estimates of how much it would cost the government to create that kind of a tax credit?

Mr. KLEINBARD. We have looked at a number of proposals along that line, Senator Salazar. But as you know, every estimate that we do is a confidential project for the individual member who requests it. Senator Wyden chose to take his proposal and publicize it. I will say that—

Senator SALAZAR. He is very public about the Healthy Americans Act. [Laughter.] I have noticed that.

Mr. KLEINBARD. But that was his choice and not ours, so I cannot give you a number that has not been otherwise released to the public. I can say that there are very difficult administrative issues which are very tedious, very difficult: how small is small; how low is low; how are you going to deal with regional differences across the country? A lot of our work in this area with members has been trying to help them understand those issues and help them specify, at the right level of detail, how exactly a proposal like that would work.

Senator SALAZAR. Thank you. My time has expired. I will only note that Senator Lincoln and Senator Durbin have been real leaders in terms of trying to address that issue with small businesses, and it is something that I very much applaud them for.

Thank you.

The CHAIRMAN. Senator Stabenow?

Senator STABENOW. Thank you, Mr. Chairman, very much. Thank you to all of you. This really goes to the heart of the issue that we have to, I think, tackle in the coming year. I want to start, Mr. Kleinbard, by thanking you for the chart looking at the fact that, whether it is directly or indirectly, the public sector, the government, is involved in funding health care.

I always kind of smile when I hear folks say, we do not want government involved in health care, we do not want government involved in my Medicare, and of course Medicare is a universal health care system. I seem to remember someone quite high up in our government saying that before. So I do think it is important that we all convey to folks that, whether it is directly or through the tax system, the public sector is deeply involved, and taxpayers are deeply involved.

I come from a State where there are a lot of folks who have employer-based health insurance. The reality for them is, in fact, their wages are not going up, they are going down. In many ways, they are taking wage cuts in order to be able to keep their insurance. It is a very, very tough situation. At the same time, I very much appreciate what Senator Wyden is doing. I think we only really get to lowering costs when it is a universal system and people stop using emergency rooms inappropriately and actually can go to the doctor. So, it is important that we have a universal system.

I have talked to Senator Wyden a lot about the fact that, for me, to go to a broad system, it is important that people who have their current insurance are able to keep it if they wish to do so. So, a couple of questions.

Mr. Gruber, I would ask specifically on Massachusetts, a couple of things. Is that an option for people in Massachusetts, and how does that work? Second, you said, which I found intriguing, that going to the system in Massachusetts, that more employers actually were expanding their coverage. I wonder if you might talk about how that happened. Explain to me how that is happening in the context of your system.

Dr. GRUBER. I think, Senator, you raised a really important point. And really, I think a fundamental lesson I feel that many of us learned from the early 1990s is, if you try to sort of overextend and try to take away things that people are happy with, it is going to make life difficult politically. I think a realistic plan needs to recognize that most Americans who get their health insurance from large firms are pretty happy with it. They wish it cost less, but they like the choices, et cetera.

So, I think it is important. It is a movement I have been calling incremental universalism, which is to incrementally get to universal coverage. By that, I mean to build on what is there. That is just what we do in Massachusetts. Most people in Massachusetts are not at all affected by our reform. If you have employer-sponsored insurance, which is the vast majority, higher than most States, you are absolutely unaffected by the reform.

What it is simply doing is trying to fill the cracks around that employer-sponsored system. The main crack it is trying to fill is for low-income people who do not have access to employer-sponsored

insurance, and right now we have about 170,000 of them, who are now getting highly subsidized government insurance.

Now, if you asked me, as an economist and modeler, gee, if we put a system like that in, what is going to happen, I would say, well, it is pretty clear what is going to happen. Since you now offer subsidized insurance to low-income people, those employers with low-income people will stop offering health insurance, and it has not happened.

Senator STABENOW. And why is that?

Dr. GRUBER. I am as surprised as you are. The only real answer—we have to study this more—I can give is, it must be the mandate. I mean, if you watched every single Red Sox game during last summer, the Red Sox supported advertising for the program and said you have to have health insurance. Everyone in Massachusetts knows you have to have health insurance. The only thing I could think of is that these people went to their employers and said, gee, I am seeing on the Red Sox games I have to have health insurance, I do not know what to do.

The CHAIRMAN. What happens if the Red Sox are losing? [Laughter.]

Dr. GRUBER. They did it the first inning. They were very smart. [Laughter.]

The CHAIRMAN. All right.

Dr. GRUBER. They went to their employer and said, I have to have health insurance, my friends all get it from their employers, I should get it from you. That is the only thing I can think of. I think we will know more in a year about what is happening. I wish I had a better answer for you.

But it is as surprising to me as it is to you, and the only explanation is the power of compulsion, the power of people saying, there is this new social contract in Massachusetts, you have to have health insurance, and employers are a good place to get it for reasons other—partly because of the tax subsidy and partly for other reasons, and that is why it is happening.

Senator STABENOW. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Lincoln?

Senator LINCOLN. Thanks, Mr. Chairman. I think all of us owe you a tremendous debt of gratitude for really bringing out this issue this year for great conversation with the intent of getting us all energized for next year, to be really able to tackle some of these issues. Our 1-day conference was a great bipartisan effort in terms of really looking into what the concerns are, what the problems are, and where we go for the answers. You have, here, compiled a panel that has been tremendous. I feel like I have had a tutorial from each one of you in your writings and in your work.

Without a doubt, Mr. Kleinbard, I want to thank you. As you have mentioned, the way that you walk through with members in terms of what kind of information we need to give you for you to be better helpful to us, is tremendous. I appreciate you and your staff. I know Tom Barthold has done the same with me. So, thank you very much. You really do go the extra mile to make sure that we understand what we are asking so we will understand what you give us back, and that is critically important.

But again, thanks to the chairman for really getting us teed up for next year, because I think it is going to be really important. I think you have us all energized, excited, and ready to go.

I know, reading through the materials for this, I became frustrated, looking at what we are spending as a Nation in terms of health care expenditures every year, that $250 billion, Dr. Baicker, that we talk about and whether or not we are getting the best efficiency out of those resources and those dollars that we are spending. I am such a firm believer that the tax code can be helpful to us. I think we want desperately in this committee to really be able to try to make that happen.

I want to try to do what Senator Salazar does, and that is to get all the questions out real quickly and let you all try to answer them.

I have one for each of you, really, to talk about. Again, Dr. Gruber, thank you. You have been enormously helpful to myself and my colleagues, Senators Snowe, Durbin, and Coleman, as we have worked through really looking at this issue. Really, 3 in 5 individuals without insurance do work. They are in the workforce. The practical idea of being able to help deliver it through employers is critically important, and it is a tool we know works if we can figure out a way to incentivize it and make it work.

We feel like, in our Small Business Health Options Program bill, our SHOP Act, that we have really worked at including in the tax code the incentives that need to be there to really get small businesses engaged, but also to make sure that they are getting value in the product that they get, that it is a meaningful coverage that people will want to use, but to use responsibly, to not over-utilize, but to use in a way that really helps. We do that by phasing in the ban on the health status ratings and some of the other things to create good pools, both in the State and nationally, if we can.

So I would just like, for Dr. Gruber, to discuss how economists are factoring in the relative value of health care dollars in the group versus the non-group markets when they look at the modeling effects of tax exclusions. I mean, when we take that tax benefit away from the employer and we send the individual out into the marketplace, do they still have the value of what that employer had and what do they find when they get into that small group marketplace?

Then also, the health savings accounts that have been mentioned. I am curious as to you all's opinion about their utilization in the next several years, and what does that do? Will they become more common? If so, is it something policymakers should be paying attention to in the context of the impact on the group market, because it is going to certainly put people into a place where—unfortunately, fewer people in Arkansas have the expendable dollars to get into HSAs, but then they get into an emergency situation or in other situations, maybe it is well care or preventive care, and they really do not have the resources to do what they need to do.

And I guess the under-insured would be the last one, Dr. Baicker, and certainly Dr. Gruber. You all may want to comment on that. Forty-two percent of all working age adults were either uninsured or under-insured. I think that is a big question for us all. Maybe you could discuss the problems of under-insurance as it re-

lates to existing tax expenditures and what we are spending there, as well as those that are being considered in various reform proposals that are out there. So, we appreciate very much all of the work you have already done to help us get to this problem, but we are going to need your help, definitely, as we move forward next year.

Thanks, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator LINCOLN. Can they just answer quickly? I am sorry.

The CHAIRMAN. I am sorry.

Dr. GRUBER. Senator Lincoln, thank you, and Senator Durbin and others, for your leadership on the SHOP bill. I think that is an excellent bill that addresses a lot of issues. I think you raised the key issue, which is, when you move from a group to a non-group setting, you move from a place, as Mr. Kleinbard mentioned, where people buy insurance in pools that ensure that it is fairly priced and the sick do not get priced out, to a market where that does not happen.

Senator LINCOLN. Right.

Dr. GRUBER. You addressed that in your bill by reforming the market. I think the big issue that one has to think about is, is that enough? Does market reform work in a vacuum? Do you need either more dollars or a mandate to make it really work? We have known States that have tried to reform the non-group market, like Massachusetts before our reform, New York, New Jersey. Their non-group market prices have gone through the roof because only the sick buy, and the healthy do not. The fundamental issue you all face going forward is, can an incremental approach work or do you need a big jump to make it work? Your SHOP bill is a terrific incremental bill. I think it does a lot of things right with subsidies and reforming the market. The big issue is going to be, is that going to be enough to make it work?

I will let Kate talk about HSAs, since she is the expert on that. Let me just mention one thing on the under-insured, because I cannot resist. We have 48 million uninsured in America, we have 200 million over-insured in America. Under-insurance is not our problem in America, over-insurance is our problem in America. I think we need to worry about the uninsured and we need to worry about the over-insured. The under-insured are not nearly as big a problem as either of those two. Let us make sure we get the money from the over-insured to help with the under-insured going forward.

Senator LINCOLN. Right. Thanks.

Dr. BAICKER. I will be very brief, but I very much appreciate your emphasis on getting value out of the system, because we do have these two simultaneous problems, that there are some procedures that are wildly overused, and then other parts of the population not getting basic care that would be of very high value. I think part of the goal of an HSA-type policy is to move some of the resources from over-use on care of questionable value to that high value, under-used type of care. It is one step in the direction of leveling the playing field.

The goal of these policies is to put out-of-pocket spending on equal footing with insured spending to try to partially remove the

bias in the tax code against out-of-pocket spending versus other ways that insurance companies could lower premiums, like better management, tiered formularies, or different physician networks. Those are all at a disadvantage relative to co-payments today.

Now, that is just one step in that direction. There is no reason to think that HSAs are the perfect way to solve the problem, and there are many ways you could reform the tax code to try to level the playing field between employer insurance, out-of-pocket spending, and non-group market insurance. The extent that HSAs will proliferate, I think, will depend on other reforms that might go even further in leveling the playing field to get higher value.

Senator LINCOLN. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

I am trying to get to the question of over-utilization. It is a big problem. I guess, what is it, Jack Wennberg up at Dartmouth University did geographic variation studies, for example, and others that point out the problem with over-utilization in some parts of the country. It is an excess supply problem: more doctors, more utilization. It is very simple.

So my question is the degree to which we could attack that with changes in the exclusion or, say, the comparative effectiveness efforts. Many of us here are thinking about kind of a separate entity, somewhat like the Federal Reserve Board, but it is private and public.

It looks at comparative effectiveness of drugs, of procedures, of medical equipment, and also Medicare reimbursing based on value rather than volume. If you look at all the ways to get at over-utilization in this country, which solutions or attempts to solve it do you think are most effective compared with those that might not be effective at all? Anybody?

Dr. BAICKER. I would love to start. I spent 6 years on the faculty at Dartmouth and worked a little on this.

The CHAIRMAN. Oh, did you?

Dr. BAICKER. Yes. And I am such a huge fan of the work that they are doing up there.

The CHAIRMAN. Yes.

Dr. BAICKER. What I think is particularly illuminating about it is that they show really wide variation in both utilization and costs, even within the Medicare program, where everyone has the same insurance.

The CHAIRMAN. Yes. Correct.

Dr. BAICKER. They are all in the same fee-for-service pool. Yet, there are parts of the country that spend 2 or 3 times as much on Medicare beneficiaries, and those are the parts of the country where those beneficiaries are the least likely to get high-quality care, not the most likely.

The CHAIRMAN. In fact, CBO did an analysis. If the entire country were to track the utilization and the better outcomes that occur in some parts of the country versus the other, the savings would be 29 percent. That is $700 billion.

Dr. BAICKER. That alone, I think, is evidence that insurance or tax reform alone is not enough to solve all of the problems. But I do think it suggests that part of the reason that variation persists is because of the insurance system that we have that is fostered

by the tax code. If we were not allowing an indefinite subsidy of any kind of care, then I do not think those differences would be as persistent.

The CHAIRMAN. So how much would comparative effectiveness efforts help?

Dr. BAICKER. I think that they would help a lot, because I think we lack information about best practices. We are not sure, in a lot of realms, what best quality is, let alone what is most cost-effective. So more information for providers would be really helpful in figuring out the cost-effectiveness of different treatments, and then passing that information on to patients.

I think it is very hard to learn about the quality of the provider that you are going to. We have seen in the Wennberg, et. al. studies that the quality variation across different parts of the country is really shocking, even in the areas of Medicare where we do know what high-quality care is.

The CHAIRMAN. Dr. Gruber?

Dr. GRUBER. I guess I want to make two points. One is, you raised the fundamental question of, if we are going to try to control costs, do we do it on the demand side by affecting what people want by maybe making them pay more for their medical care, or on the supply side, through comparative effectiveness and other things? I think there is no doubt it has to happen on the supply side, but I think the demand side is an important predicate. What I mean is the following: ultimately, if we are going to control medical costs, we are going to have to tell people they cannot get some medical care they now want.

If we continue to make it free, they will say, no, I want it. So if we could, on the demand side, make people realize some of the financial costs of over-consuming medical care, that will make supply side reform possible. So I really think they work hand in hand. The tax exclusion alone is not enough.

But by reducing the over-insurance that comes with the tax exclusion, you make the supply side reforms more possible because, if people are paying more, they will say, wow, or if they realize what their employer is paying for their insurance they will say, gee, maybe I ought to get costs down.

Now, in terms of comparative effectiveness, I mean, what is not to like? It is a wonderful idea. I think it is terrific. I love that CBO has been pushing it, and I love the efforts that you and others have been making about it.

I think, to be realistic, the question is what you do with it. I mean, I think we are all for gathering more information. The question is, is that enough, or what is the next step? In particular, to what extent can you actually compensate providers and tie the actual functioning of the health care system to that comparative effectiveness information? So I think it is a great direction, a great idea.

When you say, how will it go, that is a hard question to answer because it depends on what you do with that information. If you are aggressive and take that information and say, we are not going to pay the low-value providers, we are going to compensate the higher-value providers more, I think you would have a fundamen-

tally transformative effect on the system. But if you just collect it, it is more for academic studies.

The CHAIRMAN. Right. So how can you compensate, more along the line of payments for quality service?

Dr. GRUBER. I am not an expert in this area, but basically we have a lot of evidence on things that work, things that do not, and things that are cost-effective and not.

Basically, you can, both on the patient side in terms of what patients pay, and the provider side in terms of what you are reimbursed, tie that to what is effective. So a great example would be back surgery, the thing everybody likes to pick on. So what do we know about back surgery? We know that, if you have back pain, whether you have back surgery or not has no effect 6 months later, it just gets you better a little bit quicker.

So that seems like the kind of thing where, if I am a rich guy and I want back surgery, I should get to have it. But there is no reason that the government insurance should be paying for me to feel better somewhat quicker than not having it. Likewise, why should a provider be compensated very highly for doing that back surgery when, in fact, 6 months later it is not going to make any difference? I think that is exactly the kind of—I was much too vague for Ed to score it, but that is the kind of direction that I think we would have to go with this information.

The CHAIRMAN. All right.

You've probably given some thought to the next question. How do you start to limit the health care benefits that people are going to receive—I am addressing the demand side that you talked about a few minutes ago—in a way that is politically palatable?

Mr. KLEINBARD. Mr. Chairman, one of the adages of tax policymakers is that "an old tax is a good tax." The reason is, everybody has become habituated to it, it is priced into the economy, and by virtue of its longevity, we have sort of accepted it as part of the background environment. Arguably, the same can be said of preferences, like the employer-sponsored insurance. The old preference is a good preference, in the sense that it is fully priced into the system and into our behavior.

Therefore, I think what follows from that is that there needs to be very close attention, not just to where we are now and where we will be several years hence in the new world order, but to the transition period.

In particular, I think that there is a lot of virtue to a long transition period, as a general rule of thumb, wherever it is feasible, so the markets and behaviors can gradually habituate to the new world. We tend to look at these kinds of issues as turning on a light switch: that we are in the dark today, we will turn on the switch, and tomorrow it will be bright. But in fact it might be more of a rheostat kind of phenomenon, where we do things quite gradually over a number of years that might cushion the transition.

The CHAIRMAN. I am sorry. I am not sure I quite got that. How do you reduce benefits?

Mr. KLEINBARD. Well, for example, go back to the idea that you might want to put a cap on employer-sponsored insurance. Just take that as a free-floating idea. You could decide that, here is a target number that you want to get to, but you do not have to get

to that number the next day. You can gradually phase in a cap over a period of years.

The CHAIRMAN. Frog in the water.

Mr. KLEINBARD. I am sorry?

The CHAIRMAN. The frog in the water that goes to a boil? I do not understand.

Mr. KLEINBARD. Well, you wanted, let us say, to have a cap of $8,000 a year. You could just say, the first year the cap is $15,000, the next year it is $12,000, the next year after that it is $10,000, and then finally we get to $8,000.

The CHAIRMAN. Yes.

Mr. KLEINBARD. By doing a transition, people can adjust, the markets adjust, behaviors adjust. The one place where, unfortunately, you get hurt by long transitions is in the budget process. If the net effect is to raise taxes, if you push it outside the 10-year window, you do not get credit for it. That is a fundamental problem of a cash flow budget process.

The CHAIRMAN. Right.

Could you address mandates, both individual and employer mandates, and their consequences? Give advice on which we might look more seriously at, and why.

Dr. GRUBER. Yes. I actually do not like the term "employer mandate" because I think it gets mixed up with "individual mandate." An individual mandate is clear: it is a requirement that people buy health insurance. Employer mandate, I think, really should be known more as a play-or-pay type of restriction where, say, employers either can offer health insurance or pay income tax.

The CHAIRMAN. And why?

Dr. GRUBER. Why?

The CHAIRMAN. Why not an employer mandate?

Dr. GRUBER. Because really no one has actually proposed an employer mandate, where literally you would go to jail if you did not offer health insurance. Typically it is, you are an employer, you have to offer health insurance.

The CHAIRMAN. But would you go to jail if you do not individually buy health insurance?

Dr. GRUBER. No. No, you do not, either.

The CHAIRMAN. All right.

Dr. GRUBER. But basically, I think essentially an employer—both can play a role. I think with the individual mandate, that is essentially the one that gets to universal coverage. There is simply no way to get to universal coverage without requiring individuals—either making it free for everyone or requiring individuals to buy health insurance.

The CHAIRMAN. Now, on that point, when we had a conference at the Library of Congress—again, this committee is just trying to ramp up for next year. That is why we are having all of these hearings, et cetera. Over at the Library of Congress, at the end of the day, a couple of Senators on the Republican side said, gee, we do not like a mandate. Why? Because that is the nature of an entitlement, another entitlement. I said, what is wrong with that? The answer is, well, it prevents people from being individually responsible for their health care. If it is a mandate—I am just telling

what the thinking is so far. It may be early on in the development and understanding, but that is just what it is so far.

So I asked, what if we do not call it a mandate? What if we do not call it an entitlement? Should every American have health insurance? Oh, yes, I think I could go along with that. So a lot of this is terminology, how you package a lot of this stuff. What is your response to those who say, gee, we should not have a mandate because that sounds like an entitlement, and we have enough entitlements as it is? If you have another entitlement, people are not going to take care of themselves. They are just going to get this free health care. That is part of the answer right there. It is not free. Your thoughts?

Dr. GRUBER. I mean, I think it is an ironic criticism, because it is sort of the opposite of what a mandate is. A mandate is not an entitlement. It is a requirement that you buy health insurance. So, in fact, the real issue is, the entitlement comes on the spending side of it and how much subsidies you are going to give to people to make it affordable.

So I guess one way to construct their argument would be, gee, you cannot really mandate health insurance on people unless it is affordable, therefore, a mandate, by definition, comes with a financing stream because you have to make it affordable to the mandate. So that may be what they have in the back of their mind when they construct that argument.

The mandate itself is not an entitlement, but it is true, if you require Americans to buy health insurance, that is going to cost money. For a family in poverty right now, health insurance is 50 percent of their income. You cannot require a family of poverty to buy health insurance and spend 50 percent of their income on health insurance. It is going to have to come with a financing stream.

But I think you are exactly right. There is some terminology here which is unnecessarily scary, and I think that the point is that, if you want to have fundamental reform, if you want everyone to have health insurance coverage, if you want market reform to work so you can get to a situation where the sick do not pay many multiples of what the healthy pay, that is going to require a requirement that everyone have health insurance. I would leave it to experts like yourself to think about how to best label that to get around the problem, but I think the notion that a mandate is an entitlement, I think is sort of backwards.

The CHAIRMAN. A lot of people are kind of scared about how much all this is going to cost. I do not know what the exact number is, but some say that the American health care system is, what, 50 percent more expensive per capita than the next most expensive system in the world. This is not relevant, but our administrative costs are so much higher than are systems in other countries. We are not talking about "health care reform." You have the Massachusetts background, where it is different than other States, as you indicated. We spend, what, $2.3 trillion annually on health care in America today—public, private.

So my question is, if we have "health care reform," can we do it in a way that is there but which lowers the cost, does not increase it? If we were to do it in a way that lowers the cost, what would

some of the trade-offs be that come to your mind? I do not know that this Congress is going to want to adopt a system that increases health care. Some will. There is a bit of a debate. It has not emerged yet, but you can feel it bubbling up from the surface. Do we spend more for health care reform or can we have health care reform without spending more?

Dr. GRUBER. I think that is an excellent question. The important point to remember is, the entire cost of covering all the uninsured in America is about 1 year's health inflation. So you could cover all the uninsured in America for about $150 billion. That is maybe 1, 1½ year's health inflation. So one way to think about it is, we are already spending $2.3 trillion, we are going to add another $150 billion. Is there not some way to sort of—it seems like, you are exactly right, there should be some way to re-jigger that pie to add the extra $150 billion in without raising the size of the pie.

Senator Wyden has proposed one way that CBO and JCT have scored as budget-neutral. There are basically a lot of different directions one could go. I think to actually make it work, we have to remember that, if you are going to actually cover people with insurance, it is going to cost money, so you need to get that money from elsewhere. You can get it from the exclusion or you can get it from more fundamental efforts, like a real comparative effectiveness effort, like you have mentioned.

The CHAIRMAN. Well, this has been very helpful. Unfortunately, I am going to have to close this hearing down pretty quickly due to time constraints. But I want to thank you all very, very much. When the Senate reconvenes after the August break, I intend to continue our series of hearings. We are going to have a lot of hearings on this subject.

Frankly, this hearing today is both rewarding and frustrating because we are just starting to scratch the surface here on a lot of very important issues, and I have tons of other questions I would like to ask you. But thanks so much. I have a hunch that all of us are going to continue this dialogue for some time.

Let me now turn to Senator Wyden for any questions he might have.

Senator WYDEN. Mr. Chairman, do you have time?

The CHAIRMAN. Sure.

Senator WYDEN. That would be great. I just had a couple of extra ones.

Dr. Baicker, I did not get a chance to ask you about the nature of insurance reform. What we have tried to say is, you have to have an integrated system. In other words, you need to reform the tax code. We have all been talking about it here today. But if, as a result of making those tax code changes, people then go out into the broken insurance market, what you have is a lot of cherry-picking, and essentially only healthy people get covered and sick people go to government programs more fragile than they are. I think you are talking about putting insurance reform as a high priority, as a way to encourage innovation. Do you see the kinds of reforms I am talking about being part of a package that would also include the tax reforms?

Dr. BAICKER. Yes. One of the things that I think is particularly attractive about the package that you have put together is the flat

nature of the assistance that people get in buying health insurance with respect to the cost of the health insurance. That kind of reform of the tax subsidy, I think, is the most likely to promote high-value care by not subsidizing care on the margin, but rather subsidizing people to get insurance that is at least at a certain level, and then letting them choose above that level.

So that feature would then go hand in hand with reforms of the insurance market that would let people take the benefit to a market that gave them policies that guaranteed protection against future cost increases, as well as costs they might incur this year. So I agree with you that those two should go together and that reforming the tax code is absolutely a necessary component of a broader raft, but is not sufficient on its own.

Senator WYDEN. We are going to be calling on you, I know, often.

Because the chairman's time is short, I would just ask one other quick one. That is, both of you, I think, have written on this question that a substantial portion of the uninsured in this country, it might even be 25 percent, are people who are clearly capable of paying for health care. They are people with $50,000, $60,000, sometimes incomes well over $70,000. I think the chairman raised this question of debate about a mandate and personal responsibility.

How do you see government—and Massachusetts, I know, has been wrestling with this—dealing with this group that, for a whole host of reasons, seems to just insist on using the hospital emergency room as the principal place for where they get their health care? I would be interested, both in you, Dr. Gruber, and Dr. Baicker.

Dr. GRUBER. I think that you raised a very important issue, Senator, which is one of the arguments for a mandate, which is, there is some free riding going on. There is a set of the population, particularly young, healthy, and well-off people, who say, look, I do not need health insurance now, I can always get it when I am sick or go to the emergency room, and I am not going to get it now. They are escaping sort of the social contract we are trying to set up in Massachusetts. At the same time, it is controversial to tell people they have to do things.

I think that comes to Senator Baucus's question of how you put this package together, and explain that we are all in this together. One comforting thing of note is that the Massachusetts reform remains wildly popular. We have about a 70-percent approval rate in our State. People had to file a new tax form this year to show they had health insurance, or at least declare that they were exempt on income grounds, and 98.6 percent of people filed that tax form for the very first year. So I think it can be made to work, but I think the kind of arguments you make are going to have to be made very compellingly to address the issues that Senator Baucus brought up.

Dr. BAICKER. Just to build on that, I think you do need a strong incentive to get the young and healthy insured. Insurance is about pooling risk. If you do not get the low-risks in the pool when they are healthy, then they will lack that protection and they are likely to free-ride on the system, just as Jon said. That could be a really big carrot or a really pointy stick, or some combination of both. But

without that incentive, you face the kind of risk selection that undermines the availability of really good insurance for everyone.

I would also echo Jon's distinction between employer mandates and individual mandates. Individual mandates really do get everybody in the system. They are one form of stick that encourages that risk pooling. Employer mandates come with some attendant risks that are different. If benefits are tied to employment and, for example, employers with fewer than 20 people are excluded from the mandate, then small firms might want to avoid getting big enough to have to be subject to that mandate. If firms can avoid falling under that mandate by out-sourcing their jobs to other firms or smaller firms, they are going to shed workers who would be unprofitable to employ if subject to the mandate.

As Jon said, there are no real employer dollars in the system; there are employee dollars in the system. Employees bear the cost of health insurance through the form of lower wages, or, when their wages cannot adjust down, through the form of fewer jobs. So that is something that you would be very concerned about in designing an employer mandate that is different from an individual mandate, and part of the reason that the word "mandate" in both of them is a little confusing.

Senator WYDEN. Mr. Chairman, you have given me a lot of time this morning. I know you have a lot on your plate. We have had three of the all-stars. It has been a great panel.

The CHAIRMAN. It has been wonderful. Thank you, Senator.

I thank all of you very, very much. We will be in touch. Thank you. The hearing is adjourned.

[Whereupon, at 11:29 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

HARVARD SCHOOL OF PUBLIC HEALTH
DEPARTMENT OF HEALTH POLICY AND MANAGEMENT

KATHERINE BAICKER
PROFESSOR OF HEALTH ECONOMICS

July 31, 2008

My name is Katherine Baicker, and I am a Professor of Health Economics in the Department of Health Policy and Management at the Harvard School of Public Health. Thank you for giving me the opportunity to speak today about the important role that the way we finance health care plays in shaping the extent of health insurance coverage and the quality of the health care that we receive.

Our health care system faces several related challenges. The number of uninsured people in America is nearing 50 million. Coupled with this is a dramatic increase in health care spending, with health care comprising a rising share of both GDP and public budgets. These two trends are not unrelated: as health care costs rise, it becomes increasingly difficult for families to afford insurance. As more people become uninsured, public and private resources devoted to their care are stretched thin, resulting in less efficient care and worse health outcomes. The goals of controlling costs and increasing insurance coverage should thus go hand in hand.

Perhaps even more important than reducing costs, however, is increasing value: there is ample evidence that we do not get as much value from the health care system as we should. While much of the care delivered in the U.S. is of immense value to those receiving it, a not insubstantial share is devoted to intensive, expensive care with questionable health benefits. Proposals aimed at reducing costs should focus on reducing the use of care of such ineffective care, while ensuring the wide availability of high-quality, high-value care.

What steps could be taken to increase the value of care received throughout the health care system while promoting broader insurance coverage? One of the culprits in driving inefficient use of health resources is the current tax treatment of health insurance. Reforming this treatment, in combination with other policies, could be a crucial step in moving towards a system with higher value and more broadly accessible care.

THE CURRENT TAX TREATMENT OF HEALTH INSURANCE

Health insurance purchased through an employer is not subject to taxation, while health care purchased through the individual market or out-of-pocket for the most part is (although there are exceptions). This means that the cost of obtaining health care through an employer policy is substantially lower and that first-dollar policies are subsidized relative to other levels of cost sharing, as the following examples may help illustrate.

- Amy works for a salary of $50,000 but does not receive health insurance through her job. She spends $10,000 on health care (including both a premium for an individual market insurance policy and out of pocket costs).

- Barbara works for a salary of $45,000, and her employer pays a $5,000 premium for a basic policy that leaves her with $5,000 in out of pocket costs.

- Carol works for a salary of $40,000 and her employer pays $10,000 for a comprehensive insurance policy that covers all of Carol's care (leaving her with no out of pocket costs).

Each of these women receives $50,000 in total compensation, and for each $10,000 is devoted to health care costs, but they would have very different tax bills. If they are in the 15 percent income tax bracket and paying about 15 percent in payroll taxes (total of employer and employee shares), Barbara would pay about $1,500 more in taxes than Carol, and Amy would pay about $3,000 more than Carol. The exclusion is worth more to people in higher tax brackets. This regressivity is compounded by the fact that higher income people are more likely to have insurance through their jobs, while lower income people are more likely to be uninsured and thus have no tax benefit.

As an aside, it is worth noting that because each of these employees receives the same total compensation, employers are roughly indifferent about which package they offer. (The employer pays taxes neither on wages nor other benefits paid to employees, and that would not change in the reform proposals discussed below. The bias discussed here refers to the fact that employees pay payroll and income taxes on wages, but not on the premiums contributed by the employer.) Insurance is not a gift from employers: employees ultimately pay the cost of higher benefits in the form of lower wages. It is for this reason that the cost of employer mandates is ultimately borne by workers in the form of lower wages (and, in the case where wages cannot sink, potentially by reduced employment). Of course, many other factors affect employer costs of offering insurance and the subsequent effects on employment, and reform packages must be considered in their totality.

The net effect of this bias in the tax code is that because Amy does not have access to an employer policy, she in effect has to pay a higher price for her health care. This provision of the tax code is one of the factors that helped create our employment-based private health insurance system. It also drives higher spending on health insurance relative to other forms of taxable compensation (like wages).

A more subtle effect of this subsidization of employer-sponsored insurance policies relative to other forms of compensation like wages is that first-dollar insurance policies are favored relative to more basic policies with higher cost sharing. Suppose the cost of a routine physician visit is $100 and that everyone goes to the doctor once per year. An insurance policy that fully covers one physician visit per year will have a premium that

fully reflects that cost plus some administrative fees – say $105 more than a policy that does not cover that first visit. Most people would not choose to have insurance cover the visit in that case (much as auto and homeowners insurance do not cover routine maintenance) – but this is not the tradeoff that people with employer-sponsored insurance face. Because the premium for employer-sponsored insurance is paid with pre-tax dollars, someone in the 30 percent marginal tax bracket would in effect only pay about $71 for the visit (in the form of higher premiums), compared with $100 if it were not covered. This makes health insurance with higher premiums and lower copayments much more appealing.

Insurance plans that seek to lower premiums by increasing cost-sharing are thus at a disadvantage relative to plans that seek to lower premiums by other methods because much out-of-pocket spending is paid with after-tax dollars. This promotes plans with first-dollar coverage that may deliver very high-value care on average, but also foster the use of low-value care on the margin. Carol is likely to consume more health care than Barbara or Amy. Much of this extra care may have high value – with health benefits that are far greater than the cost of the health resources – but some may have limited value, and neither Carol nor her physician will necessarily consider the cost of the resources used if the health care has even the potential for a very small positive effect on Carol's health.

Reforming the Tax Treatment of Health Insurance

There are several ways that the tax code might be reformed to "level the playing field."

- The tax exclusion for employer-sponsored insurance could be extended to all health spending. This would eliminate the bias against individually-purchased insurance and in favor of first-dollar coverage, but would leave in place a preference for health spending relative to spending on other things (like food and housing). Whether this is a good thing or a bad thing depends on whether we are consuming too much health care on average now or too little. In all likelihood we are doing some of each.

- The tax exclusion could be capped, so that premiums for employer-sponsored plans above a certain threshold would be taxed. This would eliminate the incentive to consume more insurance above the cap, but would leave intact a preference for employer-sponsored insurance below the cap relative to individually-purchased insurance and out-of-pocket costs.

- The tax exclusion could be replaced with a revenue-neutral "flat" tax deduction or credit available to anyone covered by at least a minimum insurance policy. In the example above, Amy, Barbara, and Carol would all pay the same taxes. This would eliminate the preference for employer-sponsored insurance. It would also

eliminate the preference for health spending above the minimum policy relative to spending on other things and the preference for low copayments, while maintaining a strong incentive to have insurance coverage.

There are of course many other reforms that are possible. I will focus the rest of my discussion on the pros and cons of this third class of reforms.

Advantages of replacing the current exclusion

Replacing the current exclusion with a flat tax benefit that was tied to having insurance would create a strong incentive to be covered by insurance (the extensive margin), while eliminating the incentive to have more generous insurance or insurance of a particular form (the intensive margin). This flat benefit could be structured to be revenue-neutral and to be more progressive than the current exclusion.

Higher-value care

If particular forms of health insurance were no longer favored by the tax code, there are several changes in the type of insurance that might be available and the type of policies that people would be likely to choose. In the short run, when health insurance and wages are on equal footing, people may opt to change the mix of compensation. In the longer-run, putting different types of insurance policies on equal footing (coupled with other reforms) may foster greater innovation in insurance products and longer-run contracts in the individual health insurance market. Such longer-term contracts could help promote near-term investments in health care that would minimize long-run health costs, such as multi-year contracts, disease-management plans, portable plans, or novel co-payment structures (such as subsidization of high-value care – even paying enrollees to get flu shots – coupled with higher copayments for lower-value care). The improved value that such a reform could deliver could be felt throughout the health care system.

This also highlights the importance of tying the tax benefit to having a basic insurance policy only, rather than to a particular form of insurance or to a benefit-rich policy: structured this way, the tax benefit could go much further in ensuring that all Americans can afford the protections that insurance provides. This would make the tax benefit both more progressive and more effective than the way these substantial resources are used in our current system.

Insurance coverage

Insurance markets function best when risk is pooled across many people. Tax policy can promote greater participation, whether through "carrots" or "sticks." Replacing the current tax exclusion with a flat credit or deduction could result in many more people being covered by insurance, although the number depends on many factors that are hard

to measure. Those who are currently uninsured would receive a new tax benefit that would substantially lower the cost of insurance. Many (but not all) of them would likely take up insurance as a result. The flat credit would be more redistributive than the flat deduction, and would thus likely increase insurance coverage by more. This increase in take-up among the currently uninsured might be partially off-set by decreases in employer insurance coverage. The potential for employer erosion poses a serious transition problem that should be addressed.

Risks of replacing the current exclusion

It is unlikely that anyone designing a health system from scratch would tie insurance to employment (thus hampering labor market mobility), and would design a subsidy that accrued primarily to those with the most expensive policies and the highest incomes. Nevertheless, because that is the system that has been in operation for decades, most of the risk-pooling that occurs in insurance markets works through employer groups. While this does not mean that it is worthwhile to hold on to the current employment-based system at any cost, any reform of that system should be considered in light of the potential threat to risk-pooling and take steps to mitigate that threat.

There is an existing trend, particularly among small employers, away from offering health insurance. Leveling the playing field between individually-purchased and employment-based insurance could accelerate this trend. The magnitude of this effect is not clear (because employers offer a valuable service in selecting and bargaining with insurers, so jobs with insurance are liable to continue to be preferred by employees), but the basic mechanism is likely to operate in at least some cases. Reform proposals that favor the individual market over the employer market, such as tax credits or vouchers that could not be used in the employer market, would likely have a much larger effect on employer offering.

This suggests that extra attention should be devoted to the effect of such reforms on high-risk populations currently covered by cross-subsidized group policies. When people leave one group for another (or for the individual market), their current expected costs will be reflected in their premium upon entering the new market. While a comprehensive reform package could create such a system where all people obtain insurance while healthy, during the transition to that system some risk pools might dissolve as others formed. Sick people who had been in a group in which their risk had been pooled with other healthier enrollees would face the prospect of higher costs when their new premiums were determined. Members of this population, particularly if low-income, would need special assistance. That assistance should be thought of as a transfer program (another form of social insurance), not as health insurance, since the risk of poor health would already have been realized. While providing this assistance is a crucial component of the equity of any reform proposal, insurance systems should be designed

around generating risk-sharing with important complementary transfers handled separately.

Ensuring that those in the individual health insurance market will have access to stable insurance policies with premiums *that do not rise based on their health status* likely requires additional insurance market reforms. These reforms could be further complemented by policies such as risk-adjusted vouchers to subsidize the purchase of insurance for low-income, high-risk groups. These vouchers could be self-financing, and would promote insurance across a wider range of enrollees while encouraging cost-effective coverage. Other market reforms to promote continuity and stability of coverage would make credits more valuable to people taking them to the non-group market. A detailed discussion of these complementary reforms is beyond the scope of this testimony, but they would be crucial to the success of an overhaul of the tax treatment of health insurance.

CONCLUSION

Many policy-makers share the goal of creating a system in which everyone is covered by an affordable health insurance policy that delivers high-value care, and share the belief that our current system does not achieve that goal. Most economists would agree that our current tax treatment of health insurance is an important part of the problem, and that reforming that system would be a key component of a broader solution. Reforms that promote both broad coverage and high-value care can foster innovation and quality and help our health care dollar go further.

Statement of Senator Chuck Grassley
Senate Finance Committee Hearing of July 31, 2008
Health Benefits in the Tax Code: The Right Incentives?

I want to commend Chairman Baucus for his continued examination of our health care system and ways for reforming it. I also want to acknowledge how much I appreciate the Chairman holding this hearing.

For the past several decades, the tax treatment of health insurance has been the elephant in the room that no one wanted to talk about. For example, the most commonly recognized government programs subsidizing health benefits are Medicare, Medicaid, and SCHIP.

An often overlooked federal subsidy program for health care is run through the Tax Code. Specifically, the Tax Code subsidizes private health care spending.

The Congressional Budget Office has estimated that 55 percent of our nation's total health care spending is made up of private health care spending. This is compared to the 45 percent the government spends on Medicare, Medicaid, and SCHIP.

So while Congress has entered into long—and often pointed—debates on how we can slow the growth of public health care spending, Congress has not fully debated how we can slow the growth of private health care spending. If efforts are not taken to slow the growth of both public and private health care spending, the Congressional Budget Office projects that by 2025 such spending will make up 25 percent of our economy—rising to 50 percent of our economy in 2082.

So that's why I am glad we are having this hearing today. We are taking the first step toward recognizing the elephant in the room. That is, we are all coming together to examine the third largest federal subsidy program for health care, which is the Tax Code.

Before we begin our examination, it is important for my friends on this Committee, employers, unions, and the American public at large to understand what the current tax rules are. We all have to understand how they work. Most importantly, we all have to understand how the tax incentives for health insurance have shaped our current health care system. And, how the tax rules affect economic behavior.

I look forward to hearing from our witnesses on these matters.

There are three important points that I want to make before we hear from our witnesses.

First, many economists argue that preferred tax treatment gives people an incentive to "over-insure." They say that the preferences make people insensitive to the costs of care, and so they use more health care than they need. That drives up the cost of coverage. So I ask: if the current tax treatment of health insurance makes health insurance more expensive for everyone, shouldn't Congress consider ways to change the tax rules? I understand that the devil is in the details, but wouldn't employers and the unions want to make health care more affordable for their employees and union members? I'll bet if you ask the American public whether they want more affordable health insurance, they would want Congress to fix the rules.

Second, based on economic evidence, it is clear that employer contributions toward an employee's health insurance are not provided as a gift. Rather, employees are really paying for their own health insurance in the form of lower wages. So if employees are

really paying, requiring employers to pay their "fair-share" will only come at the expense of the employees' wages. Also, if an employee is forgoing wages to pay for health insurance, it is the employee's wages that must be reduced—or kept at the same level—to pay for rising health care premiums.

So in an extreme case, the raise or bonus a worker would otherwise receive would instead have to be allocated toward paying for his health insurance. I recognize that employees value health insurance as a benefit, but an employee should not have to work hard to maintain—and not improve—his or her "total compensation" package. It seems to this Iowa farmer that if Congress wants to allow hard-working Americans to keep more money in their pocket, health care costs have to be kept under control.

Also, if the next President and the new Congress want employers, individuals, and the government to have "shared responsibility" for financing health coverage, they should not place additional burdens on businesses. If they do, it is the employees who will ultimately pay the price. Either in the form of lower wages or the loss of health care coverage.

My third point is a point that many here on the Committee have heard before, but I believe it is worth repeating. The current tax treatment of health insurance is inequitable. Inequitable because, today, a low-income worker purchasing health coverage through an employer receives a lower tax benefit than an upper-income worker receives for the same coverage. The current tax rules are also inequitable because a person who does not purchase insurance through an employer—rather they purchase insurance on their own—generally does not receive any tax benefit at all.

Congress should consider making the tax rules more equitable. Also, Congress should not continue to disadvantage those who purchase health insurance on their own. These folks are often low-income individuals or individuals in poor health.

So if Congress wants to make health insurance more affordable, help Americans keep more of their take-home pay, and make the tax treatment of health insurance more equitable, it appears that Congress needs to fix the tax rules. The big question is how. There unfortunately is no silver bullet.

Congress has to be mindful not to disrupt our current health care system. But instead it could set a course for a smooth transition to an alternative system—whatever that alternative system proves to be. Congress also has to recognize that most Americans like the insurance that they have. In that case, they should be able to keep their insurance. They should also not be hit with a huge tax bill.

Although the employer-based health care system has some flaws, it has been an effective delivery mechanism of health insurance. I think employers should continue to have a role as a facilitator for securing coverage and also as a focal point to spur health care innovations.

We have a lot of work ahead of us. That's why I look forward to hearing from our witnesses today. I also look forward to a future hearing where we can get a perspective from employers—both large and small—on how they view the current tax treatment of health insurance.

I look forward to working with Chairman Baucus and members of this Committee, along with others in the Senate, on figuring out the best way we can meet our policy goals. And they are (1) making health insurance more affordable and (2) getting more people covered.

Statement of Professor Jonathan Gruber
Before the Senate Finance Committee

July 31, 2008

Thank you for inviting me to testify today on the interaction of health insurance and the tax code. In my testimony today I would like to do three things: describe the existing treatment of employer-sponsored insurance (ESI) by the tax code; review the problems caused by that treatment; and discuss complementary policies to blunt the effects of changing this tax treatment.

We all know the two largest government health insurance expenditures, on Medicare and Medicaid. Less well known, and even less well understood, is the government's third largest health insurance expenditure: the $250 billion/year in foregone tax revenues from excluding employer expenditures on health insurance from taxation. When MIT pays me in cash wages, I am taxed on those wages. But the roughly $10,000 that MIT will spend this year on my health insurance is not taxed, amounting to a tax break of about $4000 to me. To be clear, this exclusion is a tax break to individuals, not to firms; firms are indifferent between paying me in wages and in health insurance. But I am not indifferent about getting paid in wages or health insurance; I pay taxes on the former but not the latter.

The tax exclusion of employer expenditures from individual taxation has three flaws. First, $250 billion/year is an enormous sum of money which could be more effectively deployed elsewhere, especially through alternative approaches to increasing insurance coverage. Second, this is a regressive entitlement, since higher income families with higher tax rates get a bigger tax break; about three-quarters of these dollars go to the top half of the income distribution. Third, this tax subsidy makes health insurance, which is bought with tax-sheltered dollars, artificially cheap relative to other goods bought with taxed dollars, leading to over-insurance for most Americans.

As result of these limitations, *no health expert today* would ever set up a health system with such an enormous tax subsidy to a particular form of insurance coverage. So why don't we just remove it? Administratively, this would be straightforward: employers would report their spending on insurance as taxable wages on W-2 forms, and the government would raise the resulting revenues.

The problem is that the existing system is predicated on this tax exclusion, so policy makers must be wary about simply removing it. Many employers currently only offer health insurance because of this "tax bribe", and ending the exclusion would lead to a large erosion of employer-sponsored insurance.

There are two reasons why this might be a problem – one is wrong and one is right. The one that is wrong is the concern that we will "lose employer dollars" when ESI erodes. Both economic theory and a large body of economic evidence show that *there are no employer dollars*: the money that employers spend on insurance would otherwise just be spent on worker wages. If MIT stopped offering insurance, over a several year period my wages would rise by $10,000 to offset the lost insurance

compensation, and MIT's bottom line would remain the same. The notions of "shared responsibility" or "keeping employers in the game" are political notions, not economic ones.

The right reason to worry about the erosion of ESI is that sick and older individuals are treated much more fairly in employer groups than they will be in today's non-group insurance market. Under ESI, all individuals pay the same for insurance regardless of age or health. But in most states those who are sick or older must pay much more for their non-group insurance, and in many cases it is simply unavailable. So as employer-sponsored insurance falls we could end up with a large new set of uninsured who cannot afford, or cannot obtain at any price, non-group insurance.

Let me conclude, then, with four different things we could do to mitigate the problems caused by removing the exclusion of ESI from taxation. The first is to remove the exclusion either slowly or partially. For example, President Bush's 2005 tax policy panel suggested capping the exclusion, only subjecting insurance premiums above the national average to taxation. Alternatively, all individuals could be taxed on a portion of their employer-sponsored insurance premiums. There are a variety of alternative steps to take here and I would be happy to discuss them.

The second is to reform the outside market so that those who lose ESI are not subject to the existing vagaries of this unfair market. If health insurance companies were precluded from charging the sick much more for their insurance then it would reduce those risks. Of course, this reform cannot happen in a vacuum, as forced community rating on insurers would lead to higher prices for all.

This leads to my third suggestion, a mandate on individuals to buy health insurance. As we have shown in my home state of Massachusetts, such a mandate can lead to low prices for non-group insurance side-by-side with regulations that keep prices the same for the sick and the healthy. Moreover, one of the most striking findings from early analysis of our plan is that not only have we cut the number of uninsured more than in half, but we have *raised* the number with ESI. I would be happy to discuss our experience in Massachusetts more fully with you.

Finally, a natural alternative to existing exclusion would be to move from subsidizing *individuals* to subsidizing *firms*. The key to expanding insurance coverage in today's world is to get employers to offer that insurance – once offered, the vast majority of employees will enroll. Moreover, there are clear groups of employers who don't offer insurance – small and low wage firms. Therefore, a tax credit targeted to those small and low wage firms could expand insurance coverage. Such a credit must be well targeted, however, or it can be quite expensive. A credit that focuses its spending on those firms below 25 employees and in firms with average wages below $30,000 per year would be most effective in expanding coverage.

Thank you again for allowing me to testify today and I look forward to your questions and to helping the committee further as you tackle these difficult issues.

Summary of Testimony for Senate Finance Committee Hearing:
"Health Benefits in the Tax Code: the Right Incentives"
July 31, 2008

Tax Expenditures for Health Care

Edward D. Kleinbard
Chief of Staff
Joint Committee on Taxation

Joint
Committee on
Taxation

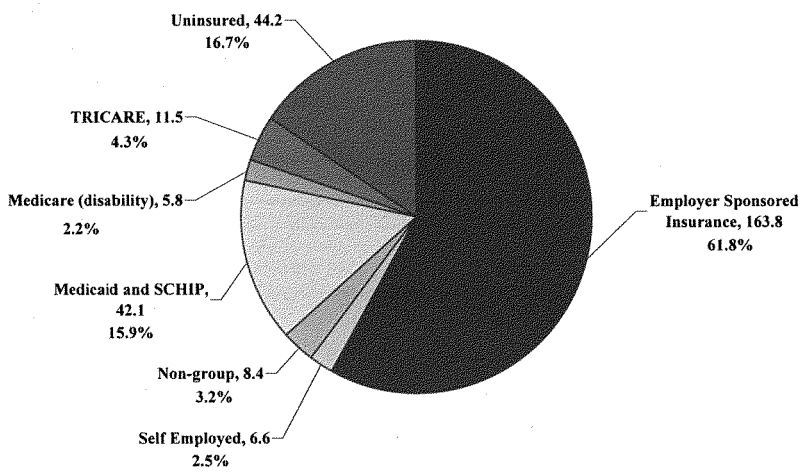
July 30, 2008
JCX-66A-08

Sources of Insurance Coverage for Americans Under Age 65

Joint Committee on Taxation

2008

[Numbers in Millions]



Source: JCT calculations based on Medical Expenditure Panel Surveys (2001-3), and Internal Revenue Service Statistics of Income 2005 data; Congressional Budget Office March 2008 baseline).

Annual Federal Subsidies for Healthcare Delivered Through the Tax Code

- Estimated value of Federal subsidies for 2007 (rounded):
  - Employer-Sponsored Insurance $245 billion
    (Includes health component of cafeteria plans)
    - Income tax exclusion (w/o deduction) ($ 145 billion)
    - FICA exclusion (pre-benefits reduction) ($ 100 billion)
  - Exclusion of Medicare benefits from taxable income $ 40 billion
  - Exclusion for self-employed individuals $ 5 billion
  - Deduction for expenses > 7.5% AGI $ 10 billion
  - HSAs < $ 1 billion
- Technical term for a Federal subsidy delivered through the Tax Code is a *tax expenditure*

Joint Committee on Taxation

Employer-Sponsored Insurance Dominates the Picture

- 164 million individuals receive health insurance through ESI plans
- Tax system used to deliver $245 billion federal subsidy for ESI plans in 2007 alone
- Employee health benefits paid by an employer are just another form of compensation
  - So employer gets tax deduction, like other compensation
- But ESI plans are tax-favored compared to other compensation:
  - Employees exclude this compensation from income (so not taxed)
  - Employees and employers both exclude this from wage base for FICA
- Substantial evidence that this favorably asymmetrical tax result largely explains dominance of ESI plans in health coverage

Joint Committee on Taxation

Joint Committee on Taxation

ESI Plans are Group Plans

- Powerful advantages to group health plans
  - If the group is determined by factors other than morbidity, the group structure mitigates problems of *adverse selection*
  - Group has superior negotiating power with insurer than an individual does
  - Group can achieve administrative savings
- So what's wrong with ESI Plans?
  - That is, once decision is made to subsidize healthcare, why not deliver the Federal subsidy through tax incentives for ESIs?

Joint Committee on Taxation

ESIs and Other Tax Expenditures Distort Government and the Economy

- ESI plans distort apparent size of budget and government
  - Make official federal budget and overall size of government look smaller than they are
  - True of *every* example of targeted tax relief
- ESI plans distort taxpayer behavior
  - Employer and employees jointly prefer nontaxable health benefits and low employee deductible over equivalent cash compensation
  - Employee insensitivity to cost of health insurance (because it is largely invisible and tax-favored)
  - Employees therefore indirectly 'overspend' on healthcare (because it is cheap compared to cash compensation)

Government Cannot Control Its Own Subsidy

- No cap on value of ESI plans, and few other limitations on design of those plans
- Employers/employees, not Federal government, define amount of Federal spending
- Subsidy varies with tax brackets of different employees (The "upside-down" subsidy problem)
- Subsidy varies with changes in individual tax rates: tax rate hikes increase the subsidy's economic distortions

Joint Committee on Taxation

Subsidy is Not Universally Available

- *Everyone* pays for the ESI subsidy, in form of higher overall tax rates to fund the $245 billion/year in implicit subsidy payments
- But subsidy is *not* available to everyone — only employees of employers that offer ESI plans get it
- Contrast this to 7.5% of AGI medical expense deduction—at least that is universally available
- Economic "job lock" of employee with chronic illness (or with sick dependent)

Joint Committee on Taxation

COMMUNICATIONS

Business Coalition for Benefits Tax Equity

Statement for the Record

Health Benefits in the Tax Code: The Right Incentives

Senate Finance Committee

Thursday, July 31, 2008

Mr. Chairman, in conjunction with the Committee's hearing on health benefits in the tax code, the 54 members of the Business Coalition for Benefits Tax Equity[1] submit these comments regarding current tax code inequities that deter some individuals from utilizing employer-provided health coverage and penalize others who do use such coverage. These inequities would be remedied by S. 1556, the Tax Equity for Domestic Partner and Health Plan Beneficiaries Act, which has been introduced by Senators Smith and Cantwell of the Committee. We hope to work with you to achieve prompt enactment of this important legislation.

Employers across the United States in increasing numbers have made the business decision to provide health benefits to the domestic partners of their employees. As of April 2008, 54% of Fortune 500 companies (270) are offering domestic partner health coverage, a more than twelve-fold increase since 1995. These employers have recognized that the provision of domestic partner health coverage is an essential component of a comprehensive benefits package. This coverage helps corporations such as those in our coalition attract and retain qualified employees and provides employees with health security on an equitable basis.

Unfortunately, federal tax law has not kept pace with corporate change in this area and employers that offer such benefits and the employees who receive them are taxed inequitably. This reduces the number of individuals who utilize employer-provided health coverage.

Issues Under Current Law

Currently, the Internal Revenue Code ("Code") excludes from income the value of employer-provided insurance premiums and benefits received by employees for coverage of an employee's spouse and dependents, but does not extend this treatment to coverage of domestic partners or other persons who do not qualify as a "dependent" (such as certain grown children living at home who are covered under a parent's plan or certain children who receive coverage through a grandparent or parent's domestic partner). In addition, when calculating payroll tax liability, the value of non-spouse, non-dependent coverage is included in the employee's wages, thereby increasing both the employee's and employer's payroll tax obligations. An employee of median income level who receives employer-provided major medical coverage of

[1] The Business Coalition for Benefits Tax Equity is a coalition of employers that supports eliminating the federal tax inequities that result when corporations voluntarily provide health care coverage to the domestic partners (and other non-spouse, non-dependent beneficiaries) of their employees. A list of the Coalition members is attached. Questions regarding this statement may be directed to James Delaplane, Davis & Harman LLP, 1455 Pennsylvania Avenue, N.W., Suite 1200, Washington, D.C. 2004, (202) 347-2230.

average cost for himself and a domestic partner faces an annual tax bill of $4,939 in income and payroll taxes, $1,729 (or 54%) more than that paid by a similarly situated co-worker with spousal coverage. However, this employee has no additional income to meet this higher tax burden. These higher tax levels can lead employees to decline the domestic partner coverage altogether, contributing to the problem of the uninsured.

The current inequitable tax regime also places significant administrative burdens on employers. It requires employers to calculate the portion of their health care contribution attributable to a non-spouse, non-dependent beneficiary and to create and maintain a separate system for the income tax withholding and payroll tax obligations for employees using such coverage.

Employers such as those in our Coalition that offer domestic partner benefits want to end these tax inequities so that the benefits we provide cover more Americans and so that all our employees are treated equitably under the tax laws. Ending the tax inequities will also eliminate the need for what are often complex communications to employees about how the tax penalties operate. Finally, ending the inequities will allow us to jettison the separate and burdensome administrative systems that we must currently establish to track the income tax withholding and payroll tax obligations for employees covering non-spouse, non-dependent beneficiaries.

S. 1556 Provides a Solution

S. 1556 would end these and other current tax inequities with respect to employer-provided coverage for non-spouse, non-dependent beneficiaries, such as domestic partners. Specifically, the bill would make the following important changes:

1. The value of employer-provided health insurance for a domestic partner or other non-dependent, non-spouse beneficiary would be excludible from the income of the employee if such person is an eligible beneficiary under the plan. Employers would retain the current flexibility to establish their own criteria for demonstrating domestic partner status. In a corresponding change, the cost of health coverage for domestic partners or other non-spouse, non-dependent beneficiaries of self-employed individuals (e.g., small business owners) would be deductible to the self-employed person.

2. The legislation would make clear that employees paying for health coverage on a pre-tax basis through a cafeteria plan would be able to do so with respect to coverage for a domestic partner or other non-spouse, non-dependent beneficiary.

3. Many employers, particularly in the collectively bargained context, use tax-exempt Voluntary Employees' Beneficiary Associations ("VEBAs") to provide health coverage. Today, VEBAs are prohibited from providing more than de minimis benefits to a domestic partner or other non-spouse, non-dependent beneficiary. The legislation would permit a VEBA to provide full benefits to non-spouse, non-dependent beneficiaries without endangering its tax-exempt status.

4. In contrast to current law, employees would be permitted to reimburse medical expenses of a domestic partner or other non-spouse, non-dependent beneficiary from

a health reimbursement arrangement ("HRA"), health savings account ('HSA") or health flexible spending arrangement ("Health FSA").

5. The value of employer-provided health coverage for a domestic partner or other non-dependent, non-spouse beneficiary would be excluded from the employee's wages for purposes of determining the employee's and employer's FICA and FUTA payroll tax obligations.

We applaud the Committee for its review of the current law tax incentives for health benefits and for giving us an opportunity to share our perspective on an important tax inequity affecting health benefits. We hope to work closely with the Committee to remedy these inequities through enactment of S. 1556.

BUSINESS COALITION FOR BENEFITS TAX EQUITY
JULY 2008

Aetna	Hartford, CT
A.H. Wilder Foundation	St. Paul, MN
Alcoa, Inc.	Pittsburgh, PA
American Benefits Council	Washington, DC
Ameriprise Financial, Inc.	Minneapolis, MN
Bausch & Lomb Inc.	Rochester, NY
Best Buy, Co., Inc.	Richfield, MN
Bingham McCutchen LLP	Boston, MA
BlueCross BlueShield of MN	Eagan, MN
Boehringer Ingelheim USA Corporation	Ridgefield, CT
Capital One Financial Corp.	Falls Church, VA
Carlson Companies	Minneapolis, MN
Charles Schwab & Co, Inc.	San Francisco, CA
The Chubb Corporation	Warren, NJ
Citigroup	New York, NY
CNA Insurance	Chicago, IL
College & University Professional Association for Human Resources (CUPA-HR)	Knoxville, TN
Corning, Inc.	Corning, NY
Cullen Weston Pines & Bach LLP	Madison, WI
Day One	South Portland, ME
The Dow Chemical Co.	Midland, MI
Eastman Kodak	Rochester, NY
EDS	Plano, TX
Ernst & Young	New York, NY
General Mills Inc.	Minneapolis, MN
HermanMiller	Zeeland, MI
Hewlett-Packard Company	Palo Alto, CA
HSBC North America	Prospect Heights, IL
IBM Corp.	Armonk, NY
ICMA Retirement Corporation	Washington, DC
Intel Corporation	Santa Clara, CA
JP Morgan Chase & Co.	New York, NY
KPMG	Montvale, NJ

Levi Strauss & Co.	San Francisco, CA
Marriott International, Inc.	Washington, DC
Medtronic, Inc.	Minneapolis, MN
Merck & Co., Inc.	Whitehouse Station, NJ
MetLife, Inc.	New York, NY
Microsoft Corporation	Redmond, WA
Miller-Coors Brewing Co.	Golden, CO
Motorola	Schaumburg, IL
Nike Inc.	Beaverton, OR
PG&E Corporation	San Francisco, CA
PricewaterhouseCoopers	New York, NY
Project for Pride in Living	Minneapolis, MN
Prudential Financial	Newark, NJ
Quorum Review, Inc.	Seattle, WA
Replacements, Ltd.	Greensboro, NC
Russell Investment Group	Tacoma, WA
Texas Instruments	Dallas, TX
TIAA-CREF	New York, NY
Time Warner Inc.	New York, NY
Verizon Communications, Inc.	New York, NY
Xerox Corporation	Rochester, NY

CPA • Center for Policy Analysis

Equitable Quality Universal Affordable Health Care (EQUAL)

Rekindling Reform
Working to Achieve Quality Health Care for All

c/o Community Studies of New York ■ 155 W. 72nd St., Suite 402 ■ New York, NY 10023 ■ email@rekindlingreform.org ■ www.rekindlingreform.org

Response by

The Center for Policy Analysis

And

Rekindling Reform

to Senate Finance Committee Hearing

Health Benefits in the Tax Code: The Right Incentives

September 4, 2008

CPA • Ellen R. Shaffer and Joe Brenner, Co-Directors • P.O. Box 29586, San Francisco, CA 94129 USA
phone: 415-922-6204 • fax: 415-885-4091 email: cpath@cpath.org • www.centerforpolicyanalysis.org

Response by
The Center for Policy Analysis and
Rekindling Reform
to Senate Finance Committee Hearing
Health Benefits in the Tax Code: The Right Incentives
September 4, 2008

We appreciate the range of hearings by the U. S. Senate Finance Committee on health care reform during 2008. We would like to respond to the presentations on July 31, 2008. The hearing, Health Benefits in the Tax Code: The Right Incentives, focused on the tax treatment of employer-sponsored health benefits. The presenters were Edward Kleinbard, Chief of Staff of the Joint Committee on Taxation, Jonathan Gruber, Ph.D., Associate Head, Department of Economics, Massachusetts Institute of Technology, and Katherine Baicker, Ph.D., Professor of Health Economics, Department of Health Policy and Management, Harvard School of Public Health.

It is alarming that some of the presentations could justify reducing or discontinuing an important source of insurance for many Americans, through tax-advantaged employment based health plans, while abandoning them to find coverage and care on their own in the market place.

Some of the witnesses suggested that employment-sponsored health insurance has resulted in many Americans being "overinsured." This is a confounding statement, at a time when 47 million Americans lack insurance entirely, many with insurance cannot afford the care they need, and the high cost of health insurance is once again receiving national attention. This sort of analysis can be used to justify proposals to reduce or eliminate favorable tax treatment for insurance, without compensating alternative coverage. It demonstrates the errors that can occur when applying traditional economic assumptions to the health care system.

Too often economic analysis fails to recognize and acknowledge the very many ways in which the health care industry does not exhibit the characteristics of perfect competition and, therefore, will respond in perverse ways to the rules and incentives used in other economic sectors. For example, greater supply – more providers – raises prices and doesn't reduce them, contrary to all the laws of economics.

On the issue of "overinsurance": Automatic payments for health care can and did drive up costs, in the absence of any kind of rational system to provide appropriate care and control costs. This is an unavoidable consequence of having insurance – people don't pay the cost of their health care, the insurance company does. It is a major reason why even economists should agree that regulation of the health care sector is necessary.

But we need to realize the person who is "requesting" the care and raising costs is seldom the patient and more often the doctor. So putting restraints on the patient, like cost sharing, doesn't really address the

problem – we need to monitor, educate, and incentivize doctors. The rest of the world has done better at achieving that kind of balance compared with the U.S., where reliance on the market has been a spectacular failure.

However, this is different from asserting that individuals have too much health insurance. Health insurance costs too much because our health care is so expensive – the prices are high, and we use services for which the price isn't related much to their value. Sometimes health insurance premiums are pegged to a group's health experience but that's still in a skewed context. The price of care has no necessary relationship to the level of coverage and benefits people have.

We are not "overinsured" compared to what we need. We're just being gouged.

For example, if an employer were providing a very high cost plan, this could mean that employees are getting unnecessary coverage, in which case some might call them over-insured. Or it could just mean that there were a lot of very sick people in the plan. If the intention is to impose additional costs on people with unusually extensive insurance, a better way to do it would be to define a comprehensive benefits package. If an employer buys more than that, the cost of the insurance for the additional services would not be tax deductible.

Some draw the unfounded conclusion that taking away insurance will puncture a hole in the price of health care. They may also assert either that this is possible without harm to access or to health; or assert that the pain is unavoidable. Relying on real world evidence, ending the tax deduction will substantially drive up the cost of insurance for employers. Based on the experience of the past few years, this would cause significant numbers of employers to drop their insurance. There is no evidence from actual experience in the U.S., including state and national programs, or elsewhere in the world, to suggest that health care prices would drop as a result or that individuals would be able to afford health care. Quite the opposite is occurring.

Economists also assume, and the Finance Committee witnesses say, that cost savings from dropping health insurance premiums will be redistributed to workers as wages. This assumes that because wages and benefits are often traded off – unions sometimes accept lower wages in return for benefits (partly because they are not taxed) – the workers who lose health insurance will get a sum equal its value in their paychecks. This may or may not occur and is unlikely to occur equitably. Employers and workers value health insurance for a lot of reasons and won't necessarily drop it when the price goes up. Conversely if they do drop insurance, they are likely to either keep the money or distribute more of it to higher paid employees. Paying for health insurance provides the same value to employees across income levels. Redirecting those funds would not provide the same equitable benefit.

There are good alternatives to employment-based insurance that work in the U.S., such as Medicare, as well as in the rest of the world, and also ways to modify it. We again acknowledge the Finance Committee's demonstrated interest in exploring a wide range of views to help the nation appreciate and move toward adopting such solutions, and encourage ongoing hearings that will continue to present different perspectives.

Statement for the
Senate Finance Committee

"Health Benefits in the Tax Code: The Right Incentives?"

July 31, 2008
215 Dirksen Senate Office Building

Submitted by:

Paul Fronstin and Dallas Salisbury
Employee Benefit Research Institute (EBRI)
T-155

The Employee Benefit Research Institute (EBRI) is a nonprofit, nonpartisan research institute that focuses on health, retirement, and economic security issues. EBRI does not take policy positions and does not lobby. www.ebri.org

Mr. Chairman and Members of the Committee:

The nonpartisan Employee Benefit Research Institute (EBRI) focuses on health and retirement benefits and has done extensive analysis on tax treatment of employment-based health insurance. EBRI, a nonpartisan research institute, does not take policy positions and does not lobby. Its research is available online at www.ebri.org Paul Fronstin is director of the Health Research and Education Program at EBRI. Dallas Salisbury is president and CEO of EBRI.

One of the most common statements of economists, when it comes to health insurance, is that "there are no employer dollars involved, since in the absence of the health insurance being provided, the worker would be paid in added salary or wages." We must respectfully disagree with this statement as it applies to the individual, even were it to apply to all covered workers as a group, in terms of aggregate funds. Even then, adjustments would occur over the very long term, not immediately or in even the short term of a decade. Consider Congress itself, where the annual salary increases are determined with little or no consideration of what is being spent on employee health insurance. Consider the individual at the minimum wage, or others, who have health insurance added by their employer. Employer decisions on whether or not to provide benefits are generally made for the full workforce, relative to total cost, and not on a micro- or individual-worker basis. Large employers that self-insure know that the actual cost of providing the benefit varies widely across workers as a function of health status, age, etc.

EBRI's most recent analysis of the topic of today's hearing was published in the September 2007 *EBRI Issue Brief,* no. 309: "Health Insurance and Taxes: Can Changing the Tax Treatment of Health Insurance Fix Our Health Care System?" The co-authors are Paul Fronstin and Dallas Salisbury of EBRI. Full text is available online at www.ebri.org/pdf/briefspdf/EBRI_IB_09-20074.pdf

Highlights

- Proposals to change the way in which health benefits are taxed have far-reaching implications for employer health plan design. They also affect the viability of employment-based health benefits generally and raise questions regarding the future of the employment-based health benefits system.
- Currently, employers can deduct from corporate taxable income the cost of providing health benefits as a business expense.
- With respect to workers, the amount that employers contribute towards health benefits is excluded, without limit, from workers' taxable income. Employers can also make available a premium conversion arrangement as part of the FSA or as part of a cafeteria plan, which allows workers to pay their share of the premium for employment-based health benefits with pretax dollars.
- For individuals who do not receive employment-based health benefits, total health care expenses (including premiums) are deductible only if they exceed 7.5 percent of AGI, and only the amount that exceeds 7.5 percent of AGI is deductible. This deduction is allowed only when an individual itemizes deductions on his or her tax return, and it is not widely used.
- Comprehensive tax reform as it affects health insurance and health care costs could mean the end of employment-based health benefits. Were the current tax treatment of health benefits replaced with some form of a broad-based tax credit or tax cap that was available either in the employment-based system or the non-group market, healthy workers would opt out of employment-based coverage for the non-group market.

- To the degree that young and healthy workers leave the employment-based system, workers remaining in the system will be disproportionately older and unhealthy, which will drive up premiums in the system. As premiums increase, the youngest/healthiest workers will move to the non-group market, leaving relatively older/less healthy workers in the employment-based system, which will continue to drive up premiums for employer coverage. This phenomenon is known as the "death spiral" because it means the death of employment-based health benefits as a result of continued and increased adverse selection. Were the employment-based system go into the death spiral, employers could eventually drop coverage.

Introduction

Proposals to change the way health benefits and health care costs are treated under the tax code have one thing in common—they would eliminate the current preferential tax treatment for employment-based health benefits and replace it with some form of a flat tax credit or tax deduction for all taxpayers with qualifying private health insurance. From both a budgetary and political perspective, the tax treatment of employment-based health benefits is an almost inescapable target. Tax-favored employment-based health benefits accounted for $145.3 billion in foregone income tax revenue and $100.7 billion in foregone FICA tax revenue in 2007.[1] Foregone income tax revenue is predicted to amount to $628.5 billion over the five-year period from 2007–2011.[2] The tax proposals have far-reaching implications for employer health plan design, including the viability of many of the newer consumer-driven health plans that use health reimbursement arrangements (HRAs) or health savings accounts (HSAs) to increase worker engagement and payment responsibility relative to employer payments. The tax proposals also affect the viability of employment-based health benefits generally and raise questions regarding the future of the employment-based health benefits system.

Current Tax Treatment of Health Insurance

The tax treatment of health benefits has been formed in the tax code through a series of laws and rulings that date back to the 1920s. Currently, employers can deduct from corporate taxable income the cost of providing health benefits as a business expense. This means that whatever an employer spends on health insurance or health benefits on behalf of workers is considered a business expense just as wages and salaries are a business expense. In other words, employers get the same deduction in calculating taxable business income when they choose to provide compensation in the form of health benefits as they would were they to provide compensation in the form of wages and salaries and should therefore be indifferent from an income tax point of view between providing health benefits or cash wages.

Employers do however get a break on payroll taxes when compensation is provided in the form of health benefits instead of wages and salaries. They do not pay the 6.2 percent payroll tax for Social Security for workers whose incomes are below the Social Security wage base, which was set at $102,000 in 2008. They also do not pay the 1.45 percent payroll tax for Medicare for all levels of wages.

With respect to employees (including the self-employed), the amount that employers contribute towards health benefits and health insurance is generally excluded, without limit, from workers' taxable income. In addition, workers whose employers sponsor flexible spending accounts (FSAs) are able to pay for out-of-pocket health care expenses with pretax dollars

through the FSA, meaning they are not taxed on the amount of money that is put into the FSA. Employers can also make available a premium conversion arrangement as part of the FSA or as part of a cafeteria plan, which allows workers to pay their share of the premium for employment-based health benefits with pretax dollars. Workers also do not pay income tax on employer contributions to FSA's and HRA's.

Individuals are able to deduct from taxable income contributions made to a health savings account (HSA) if they have health insurance with a minimum deductible of at least $1,100 for individual coverage or $2,200 for family coverage. In order to make tax-free contributions to an HSA, the health plan must also impose a maximum $5,800 out-of-pocket limit for individual coverage, and an $11,200 limit for family coverage. Deductibles can be as high as the out-of-pocket maximum, which would mean there would be no cost sharing above the deductible, though there are exceptions for plans that include benefits for out-of-network providers. There are other restrictions as well. Regardless of who contributes to the account, annual contributions are tax-free to the individual who owns the account, up to a limit of $2,900 for individual coverage and $5,800 for family coverage. Persons ages 55 and older are allowed to make "catch-up" contributions as well. In 2008, a $900 catch-up contribution was allowed, and is being phased in to $1,000 by 2009.[3] Unspent balances in an HSA grow tax-free, and distributions from an HSA are tax-free when used for qualified medical expenses and certain premiums.

For individuals who do not receive employment-based health benefits, total health care expenses (including premiums) are deductible only if they exceed 7.5 percent of AGI, and only the amount that exceeds 7.5 percent of AGI is deductible. This deduction is allowed only when an individual itemizes deductions on his or her tax return, and it is not widely used. The standard deduction is larger than the sum of itemized deductions for most taxpayers, and most do not have deductible medical expenses that exceed 7.5 percent of AGI. In 2001, about one-third of all individual income tax returns had itemized deductions, but only 17 percent of these claimed a medical expense deduction, accounting for about 6 percent of all tax returns.[4] There is one exception to the 7.5 percent AGI rule, however. Contributions to an HSA are fully deductible from taxable income and are not subject to the 7.5 percent AGI threshold.

Issues With Changing the Tax Treatment of Health Benefits

Comprehensive tax reform as it affects health insurance and health care costs could mean the end of employment-based health benefits. Were the current tax treatment of health benefits replaced with some form of a broad-based tax credit or tax cap that was available either in the employment-based system or the non-group market, healthy workers would opt out of employment-based coverage for the non-group market.

Insurers may respond to a broad-based tax credit, for example, by designing health plans to attract the young and/or healthy and the uninsured. They may advertise the fact that certain health plans will be "free" in the sense that the tax credit would cover or more than cover the premium. The availability of these plans will be a draw to young and healthy workers with employment-based health benefits. If young workers leave employment-based health benefits for the individual market, the employment-based system will suffer from adverse selection that pushes up the cost of the employment-based coverage and employers will rethink their role in providing health benefits.

To the degree that young and healthy workers are able to and do in fact leave the employment-based system, workers remaining in the employment-based system will be

disproportionately older and unhealthy, which will drive up premiums in the employment-based system. The employment-based system will then be in a vicious cycle. As premiums increase, the youngest/healthiest workers will move to the non-group market, leaving relatively older/less healthy workers in the employment-based system, which will continue to drive up premiums for employer coverage. This phenomenon is known as the "death spiral" because it means the death of employment-based health benefits as a result of continued and increased adverse selection.

Were the employment-based system go into the death spiral, employers could eventually drop coverage. Coverage would be dropped for a number of reasons. Employers offer health benefits primarily to be competitive in the labor market.[5] Health benefits are by far the most valued benefit in the workplace[6] and employers offer them to recruit and retain workers. If workers dropped health benefits and instead found coverage on their own in the non-group market, employers would stop offering coverage because they perceived that workers did not value coverage.

As workers leave the employment-based system for the non-group market and drive up premiums in the employment-based system, employers will find coverage less and less affordable and will eventually drop that coverage. Third, employers are already concerned about the rising cost of health benefits and some are looking for an excuse to drop those benefits.[7] Equalizing the tax treatment of employment-based health benefits and non-group insurance may be the excuse employers use to drop health benefits altogether. Small employers would likely be the first to drop benefits because they struggle with affordability more than large employers. However, large employers have also been struggling with the cost of health benefits, and while they are generally hesitant to drop benefits if their workers will have a difficult time getting coverage in the non-group market, employers are always looking for a competitive edge, and it only takes one large employer to drop health benefits in order to trigger a movement of large employers away from health benefits.

Employers may drop benefits because of the additional administrative costs related to valuing the benefit. Under proposals to change the tax treatment of health benefits, employers will be required to value health benefits and report the value of health benefits as imputed income. While the details of how employers would be able to value health benefits would likely be worked out in regulations, employers may have some choices to make when it comes to valuation, and these choices would likely affect workers and the value they place on employment-based health benefits.

Employers provide health benefits either by purchasing a fully-insured health plan from an insurer, or by self-insuring. Groups that are fully insured pay an insurer a per-person premium, with an average price that varies by employee population characteristics and health care use. Self-insured employers typically divide the total cost of the health plan by the number of covered employees to derive an average "premium equivalent." This premium equivalent is used to determine COBRA premiums in a self-insured setting. If employers were required to value health benefits for employee income and tax purposes, the current method that employers use to value premiums would be beneficial to some workers but not to others.

It is clear from employer experience with COBRA that the method used to value premiums is beneficial for some workers but not to others. Employers are allowed to require that COBRA beneficiaries pay 102 percent of the premium for COBRA coverage. Because workers are generally required to pay the full premium on an after-tax basis (as opposed to paying a portion of the premium on a pre-tax basis while at work), there is a self-selection issue regarding who takes COBRA. Employers have found that COBRA beneficiaries incur on average about

50 percent more health care expenses than the average population or insured workers.[8] This self-selection occurs because COBRA beneficiaries tend to be older, less healthy workers who continue coverage because COBRA premiums (even at 102 percent on an after-tax basis) are more affordable than premiums for comparable insurance in the non-group market.

Under a self-insured health plan there is no premium: Employers pay claims as they are incurred. If employers had to value health benefits for tax purposes, would they value the benefit at the average COBRA equivalent premium, or would each worker be assigned a value corresponding with his or her actual or expected use of health care services? Is the value of health benefits lower for lower-risk individuals than it is for higher-risk individuals? If the value of the benefit is determined by health risk, higher-risk individuals would be assigned a higher value for health benefits, and, all else equal, would pay higher taxes associated with the value of the benefits that is above the exclusion cap. If the value of the benefit is not associated with risk, but instead valued at the community rate, higher-risk individuals would benefit because they would, on average, use more health care services than the average value of the benefit. The method used to determine the value of the health benefit may drive adverse selection. If the average premium was used to value the benefit, lower-risk individuals would likely opt out of the plan in order to seek less costly health insurance on their own. As mentioned above, when lower-risk individuals leave the insurance pool, the average cost of insurance rises for everyone who remains in the pool. The process would continue until only higher-risk individuals remained in the pool, making the insurance plan unsustainable.

Valuing the benefit would also be complicated for employers operating in multiple locations. Employers with sites in different states could face multiple valuations because the cost of the benefit package could vary in different geographical regions for a number of reasons. The underlying prices for health care service may be higher in one part of the country over another, or demographic differences in different parts of the country for the same employer may affect the valuation of health benefits.

Would Tax Credits Be Effective in Expanding Coverage?

Tax credits have been on the radar scope of policymakers even before President Clinton proposed comprehensive reform to the health insurance system.[9] Unsuccessful tax credit bills were introduced by both Democrats and Republicans, and in some cases, bills were co-sponsored by both. Cunningham (2002) describes what has become the "joint custody" of tax credits among Democrats and Republicans.[10] Sen. Lloyd Bentsen (D-TX) was a principal architect of the unsuccessful health insurance tax credits enacted during the first Bush administration in 1991. In 1999, House majority leader Dick Armey (R-TX) and ranking Ways and Means Democrat Pete Stark (D-CA) jointly endorsed tax credits on the opinion page of the Washington Post, but the proposal did not go anywhere.[11] Also in 1999, Stuart Butler of the conservative Heritage Foundation and David Kendall of the (Democratic) Progressive Policy Institute made a joint proposal, as did Reps. Jim McCrery (R-LA) and Jim McDermott (D-WA) in 2000.[12]

A primary issue with a tax credit is whether the tax savings is large enough to induce the uninsured to purchase health insurance. The ability of a tax credit to reduce the uninsured depends heavily on several key design issues, such as the size of the tax credit relative to income and income levels overall. Previous research has shown that for single workers with income at 150 percent of the federal poverty level (FPL), only 48 percent would gain coverage even if the tax credit was set to 79 percent of the premium.[13] In addition, a tax credit equal to the full

amount of the premium would result in only 75 percent of the population of single workers at 150 percent of FPL receiving coverage.

The findings of Thorpe (1999) are reinforced by experiments driven by The Robert Wood Johnson Foundation's Health Care for the Uninsured Program in the late 1980s that were able to reduce premiums for the self-employed and workers in small firms. Despite premium reductions ranging from 9 to 60 percent, with most in the 25 and 50 percent range, no single site in the experiment reached 10 percent of its' target market.[14] Hence, even very generous tax credits may not be large enough for a significant portion of the low income population to purchase health insurance.

Endnotes

[1] See Table 1 in http://www.jct.gov/x-66-08.pdf.

[2] See Table 3 in http://www.house.gov/jct/x-32-08.pdf. This estimate includes the exclusion of employer contributions for health care, health insurance premiums, and long-term care insurance premiums.

[3] Catch-up contributions are not indexed to inflation.

[4] Lyke, Bob. "Tax Benefits for Health Insurance and Expenses: Current Legislation." *CRS Issue Brief for Congress*. Congressional Research Service, Library of Congress, February 23, 2005.

[5] Fronstin, Paul. "The Future of Employment-Based Health Benefits: Have Employers Reached a Tipping Point?" *EBRI Issue Brief* no. 312 (Employee Benefit Research Institute, December 2007).

[6] Helman, Ruth, and Paul Fronstin. "Public Attitudes on the U.S. Health Care System: Findings from the Health Confidence Survey." *EBRI Issue Brief* no. 275 (Employee Benefit Research Institute, November 2004).

[7] Christensen, Rachel, Paul Fronstin, Karl Polzer, and Ray Werntz. "Employer Attitudes And Practices Affecting Health Benefits And The Uninsured" *EBRI Issue Brief* no. 250, October 2002.

[8] See http://www.cch.com/press/news/2006/20061206h.asp.

[9] Fronstin, Paul. "Employment-Based Health Insurance: A Look at Tax Issues and Public Opinion." in *Severing the Link Between Health Insurance and Employment*, Dallas L. Salisbury (ed.), (Washington, DC: Employee Benefit Research Institute), 1999.

[10] Cunningham, Robert. "Joint Custody: Bipartisan Interest Expands Scope Of Tax-Credit Proposals." *Health Affairs* Web Exclusive, September 18, 2002.

[11] Armey, Dick, and Pete Stark, "Medical Coverage for All: The Ultimate Congressional Odd Couple Weighs In." *Washington Post*, 18 June 1999.

[12] See Butler, Stuart, M. and David B. Kendall. "Expanding Access and Choice for Health Care Consumers through Tax Reform." *Health Affairs* (Nov/Dec 1999): 45–57. Cunningham, Robert. "Joint Custody: Bipartisan Interest Expands Scope Of Tax-Credit Proposals." *Health Affairs* Web Exclusive, September 18, 2002. Fronstin, Paul. "Employment-Based Health Insurance: A Look at Tax Issues and Public Opinion." in *Severing the Link Between Health Insurance and Employment*, Dallas L. Salisbury (ed.), (Washington, DC: Employee Benefit Research Institute), 1999. Miller, M. "Health Care: A Bolt of Civic Hope," *Atlantic Monthly*, October 2000, www.theatlantic.com/issues/2000/10/miller.htm (6 August 2002).

[13] Thorpe, Kenneth E. "Changing the Tax Treatment of Health Insurance: Impacts on the Insured and Uninsured." in *Severing the Link Between Health Insurance and Employment*, Dallas L. Salisbury (ed.), (Washington, DC: Employee Benefit Research Institute), 1999.

[14] W. David Helms, Anne K. Gauthier, and Daniel M. Campion. "Mending the Flaws in the Small-Group Market." *Health Affairs*, Summer 1992; 11(2): 7–27.

National Association of Health Underwriters

America's Benefits Specialists

The Tax Code and Health Insurance Coverage

A Discussion of Issues Related to Changing the Federal Tax Exclusion

July 2008

Executive Summary

- The federal Tax Code helps to encourage private health insurance coverage in a number of ways, with the largest aspect being the so-called federal "tax exclusion" in employer-sponsored insurance (ESI). The exclusion refers to the amount of an individual's group health insurance coverage premium paid by an employer, which is not taxable to the employee as income.
- The tax exclusion has helped incentivize nearly two-thirds of the U.S. population under the age of 65 (more than 160 million lives) to be covered by quality private health insurance through the employer setting. ESI has many advantages, including controlled entry into and exit from the program, which ensures the even distribution of risk; federally guaranteed consumer protections like portability rights; the ease of group purchasing and enrollment and the economies of scale of group purchasing power.
- The amount of federal tax subsidy (or foregone revenue) attributable to the exclusion for employer payments for health insurance and health care (for self-insured plans) was approximately $106 billion for FY 2007 (about three percent of our nearly $3 trillion annual federal budget outlays).
- Proponents of revamping the current tax exclusion have focused on two criticisms: it is unfair that individuals who happen to work for an employer offering insurance get a tax break while those who seek to purchase insurance elsewhere do not; and due to the subsidy, there is increased demand for health insurance/services, which contributes to higher health care costs for everyone.
- The issue of tax equity/fairness is a shortcoming of current law, but can be addressed with extending tax incentives to those who do not have access to ESI. Overutilization or inappropriate care can be attributable to many factors, but the goal of tax subsidies for health insurance is to make care more accessible and affordable, so induced demand of *insurance*, at some level, is inevitable. But is important to distinguish that insurance coverage does not necessarily equate to timely and appropriate use of medical care. Any constructive debate over revamping the federal tax treatment of health care must address not only what a new system might seek to accomplish, but also what tradeoffs and unintended consequences might be, and who would be likely to be most affected by any changes.
- Many proposals for changing the tax exclusion would call into question the future role of employers in providing health insurance, as capping or eliminating the exclusion could have significant implications for the composition of large-group risk pools under ESI that have helped make coverage affordable and desirable.
- NAHU agrees that the Tax Code can and should be used to encourage health insurance coverage, and that policymakers should look to build on the successes that ESI has achieved to date.

The Tax Code and Health Insurance Coverage

The National Association of Health Underwriters (NAHU) is the leading professional trade association for health insurance agents and brokers, representing more than 20,000 nationwide. NAHU members service the health insurance policies of millions of Americans and work on a daily basis to help individuals and employers purchase health insurance coverage and make the most out of that coverage. The organization has a unique perspective of the health insurance market place, because its members are intimately familiar with the needs and challenges of health insurance consumers, and have a clear understanding of the economic realities of the health insurance business, including both consumer and employer behavioral responses to public policy changes.

The federal government has a rather long history of involvement in the purchase of health insurance, and through current tax policy, has incentivized nearly two-thirds of the U.S. population under the age of 65 (more than 160 million lives) to be covered by quality private health insurance through the employer setting. For more than 60 years, employer-sponsored insurance (ESI) has helped to effectively pool individual health insurance risks over time and across groups, with remarkably little government interference. NAHU strongly agrees that the Tax Code can and should be used to encourage as many people as possible to be covered by health insurance. It believes that policymakers should look to build upon the successes that our health care delivery system has achieved to date.

NAHU stands for the proposition that all Americans deserve a health care system that delivers both world-class medical care and financial security. Americans deserve a system that is responsible, accessible and affordable. This system should boost the health of our people and of our country's economy. That being said, the system must also be realistic.

The time is right for a solution that controls medical spending and guarantees access to affordable coverage for all Americans. NAHU believes this can be accomplished without limiting peoples' abilities to choose the health plan that best fits their needs and ensures them continued access to the services of independent state-licensed counselors and advocates. It also believes that, given that the vast majority of privately insured Americans receive their health insurance coverage through their employers or the employers of their spouses or parents, the preservation of both the employee federal tax exclusion and the deduction for employers' health care provision costs is critical.

NAHU is at the forefront in developing solutions to current health care challenges by developing a set of recommendations for a stronger health care delivery system. NAHU's ***Healthy Access*** proposal is a comprehensive approach to meeting the country's various challenges of cost, access and quality, and represents a yardstick for evaluating other proposals. Details of ***Healthy Access*** can be found on NAHU's website at:

http://www.nahu.org/legislative/healthyaccess/index.cfm.

(Please see Appendix A for a summary.)

The federal Tax Code helps to encourage private health insurance coverage in a number of ways, but the largest tenet of the tax policy is the so-called federal "tax exclusion" in ESI. This refers to the amount of an individual's group health insurance coverage premium paid by an employer, which is entirely excluded from the employee's income for income and payroll tax purposes. As a result of this tax policy/subsidy/expenditure, the after-tax cost of health insurance is discounted, and job-based insurance can be anywhere from 15% to 50% less expensive than buying coverage individually.[1]

Merits of the Tax Exclusion/Employer-Based System

Through the tax subsidy provided to purchase private health insurance in the employer setting, most Americans have access to health plans that are innovative, flexible and efficient. Benefits change with the times, new strategies for cost containment are adopted and re-evaluated, and private employer-based plans are able to bargain very effectively on behalf of their covered populations. For the majority of all Americans under the age of 65, ESI is a reliable and cost-effective method for attaining high quality health insurance coverage. Significant margins of Americans rate their health insurance positively.[2] And, despite much rhetoric about the erosion of ESI, rates of private employer-sponsored coverage have remained relatively constant, with the proportion of workers having coverage either through their own employer or someone else's employer averaging between 70 and 74% over the past 15 years.[3]

Other tax exclusion features of the current Code provide that active employees participating in a Section 125 cafeteria plan may pay their share of premiums on a pre-tax basis through salary reduction. Such salary reduction contributions are treated as employer contributions; thus, they are also excluded from gross income and payroll taxes. Reimbursements under employer plan for medical expenses are also excludable from gross income and wages. There is no limit on the amount of employer-provided health coverage that is excludable.

The IRS definition of "health plan," for purposes of the exclusion for employer-provided health coverage, applies to more than just traditional health insurance plans. Account-based arrangements commonly used by employers to reimburse medical expenses of their employees (and their spouses and dependents) include health Flexible Spending Accounts ("FSAs") and Health Reimbursement Arrangements ("HRAs"). Generally, contributions to these accounts are allowed to be made on a pre-tax basis.

One of the main reasons that federal tax policy has encouraged health insurance purchased through one's employer is that, a group of people working for a company often provides a convenient, stable and efficient risk pool for health insurance. Employer-sponsored health insurance coverage has many advantages, including the controlled entry into the program, which ensures the even distribution of risk; federally guaranteed consumer protections like

---

[1] The after-tax discount on the price of health insurance under ESI is roughly equal to an individual's combined marginal income and payroll tax rates, but additional premium differences between ESI and other non-group products are attributable to the fact that ESI generally is more generous coverage than in the individual market, and ESI is able to mitigate adverse selection through controlled entry into and exit from health insurance plan products. Exclusion from applicable state income tax can also be a factor.

[2] Kaiser Family Foundation, Health Insurance Survey, October 2004.

[3] EBRI Issue Brief on "The Future of Employment-Based Health Benefits: Have Employers Reached a Tipping Point?" by Paul Fronstin, No. 312, December 2007.

portability rights; the ease of group purchasing and enrollment and the economies of scale of group purchasing power. In addition, it is a means for employers to provide equitable contributions for their employees.

Benefits available to group health insurance consumers under ESI are generally much more extensive than those available to consumers spending a similar amount in the individual market. For example, many individual policies substantially limit coverage of items that many group consumers consider to be standard, such as prescription drugs, maternity benefits and mental health benefits. Group health insurance also provides a reliable payment mechanism for millions of Americans, which helps keeps costs down and results in many more insured than if individuals were expected to apply separately. These benefits seem to be recognized—at least implicitly—by most of the U.S. adult population. Nearly 70% of American workers receive health coverage through their employers. Take-up rates for ESI are strong at almost 85%, with fewer than five percent of workers eligible for health benefits being uninsured.[4]

Offering health insurance to workers is in employers' interest. Although under no federal legal obligation to offer subsidized health insurance, 99% of large firms (200 or more workers) and more than 83% of firms with 25 or more workers offer health benefits.[5] Most do so for a somewhat simple reason: a healthy workforce is directly linked to healthy productivity. Thus, employers' ability to offer incentives to differentiate nonwage-related benefits helps them to attract the best workers and remain competitive. The government further supports ESI through the Tax Code by recognizing firms' insurance premiums paid on behalf of their workers as a business cost, which are generally deductible for tax purposes.

The amount of federal tax subsidy (or foregone revenue) attributable to the exclusion for employer payments for health insurance and health care (for self-insured plans) is approximately $106 billion (about three percent of our nearly $3 trillion annual federal budget outlays). When one considers that, for this "expenditure," some 160 million lives are helped to be covered by private health insurance, the federal government averages about a $675 annual subsidy for each covered individual. NAHU maintains that this is a desirable cost-benefit ratio.[6]

Although the employment-based health benefits system reduces transaction costs, may lower premiums for some people who otherwise could not afford health insurance and helps sustain a great percentage of the population with coverage, there are certainly areas where it

---

[4] Fronstin, EBRI Issue Brief No. 312, December 2007.

[5] "Employee Health Benefits 2007 Annual Survey," (#7672), The Henry J. Kaiser Family Foundation and Health Research and Educational Trust, September 2006.

[6] Joint Committee on Taxation, "Estimates of Federal Tax Expenditures for Fiscal Years 2007-2011," (JCS-3-7, September 2007). The tax exclusion of amounts of employer-provided health insurance purchased through cafeteria plans is estimated to be an additional $30 billion per year. Some observers of the tax exclusion point out that its cost to the government is closer to $200 billion per year, considering foregone Social Security (OASDI) and Medicare (HI) payroll taxes. While this is true, it bears mentioning that the amount of taxable payroll these foregone revenues represent is negligible in terms of both programs' current and future budgetary needs. And in Social Security's case, including employer-paid health care coverage in the Social Security wage base would lead to increased outlays for Social Security benefits in the future that could offset over the long run a significant part of any added payroll tax revenues today. See John Shiels and Randall Haught, "The Cost of Tax-Exempt Benefits in 2004," *Health Affairs Web Exclusives*, February 25, 2004.

can be improved to help make it more affordable and accessible. Again, for a further analysis of the systematic issues beyond the Tax Code, NAHU's ***Healthy Access*** proposal lays out a vision for offering more risk pool options; minimizing mandates; constraining medical costs; and maximizing health care resources, including the extension of tax incentives especially for those outside the employer system.

Despite its merits, the employer-based system is not suited for everyone's health insurance needs. There are obvious problems and questions that would arise were the government to force the employer system on populations that do not naturally belong to it. How do we deal with part-time workers, workers who change jobs frequently, low-wage workers and workers in small firms? These are the workers whose job-based coverage has been eroding the most. It does not make sense to force part-time workers, multiple job holders, or workers in small, unstable businesses to obtain coverage through their jobs. Often, they and their employers will have gone their separate ways before the coverage even becomes effective. In such cases, an employer mandate may be ineffective and, inadvertently, may also become a hidden payroll tax on low-wage workers in small businesses. For individuals in these situations, a more level playing field with tax subsidies in the individual market (in tandem with ESI) merits serious consideration, and would also assist with health insurance portability (see section on pg. 10 "Extending Tax Equity for Health Insurance").

Issues Related to Eliminating or Capping the Tax Exclusion for Some Other Tax Preference

Though well intentioned, proposals to eliminate or cap the current tax exclusion and possibly substitute it with some other tax preference raise significant issues that merit further evaluation. Proponents of eliminating or capping the employer exclusion generally focus on two issues: health insurance affordability and tax equity.

Affordability

In terms of affordability, there are some who believe that third-party payment structures shroud the true cost of health care/insurance and, that combined with the attendant tax exclusion, they remove incentives for the wise use of health care dollars. They contend that overutilization of health services occurs as a result of this dynamic, which contributes to the increase in health care costs for all.

There is an assumption in this line of thinking that workers who are offered a choice of non-taxable employer-paid coverage will select the most expensive health plan available rather than the plan that is the best value for the dollar. There is a further assumption that because of a disconnect between price and product purchasing decisions common with other goods and services, there is induced demand for health services that drives costs higher for everyone.

NAHU certainly agrees that overutilization of health care services is a problem that can have a significant impact on health insurance costs. As is discussed in ***Healthy Access***, a national effort to constrain the growth of medical care costs will do more to increase the affordability of health insurance than any market reforms, because health insurance premiums are directly tied to the cost of medical care. However, the goal of tax subsidies for health care is to make it more accessible and affordable, so induced demand for *insurance*, at some level, is inevitable.

However, it is important not to confuse insurance coverage with the rate and dimensions of medical care utilization. Insurance coverage and the comprehensiveness of benefits do not necessarily equate to consumers utilizing (appropriately or inappropriately) the services of such coverage. In fact, unmet medical needs or delayed care is a phenomenon associated with both the insured and uninsured alike. The number and proportion of Americans (both insured and uninsured) reporting going without or delaying needed medical care has been increasing by some measures (i.e., offsetting evidence of underutilization). According to the Center for Studying Health System Change, one in five Americans (59 million people) reported not getting or delaying needed medical care in 2007, up from one in seven (36 million people) in 2003.[7] Those reporting either an unmet need or delayed care (again, both insured and uninsured) cited reasons ranging from concern about medical care cost, insurance or provider issues and personal reasons (such as lack of time or procrastination).

There is also considerable evidence that overutilization of health care service can be attributed, at least in part, to provider payment paradigms based on the volume of discrete services rather than episodes of care.[8] Another continuing problem is the development and exacerbation of health conditions that require more expensive modes of treatment and that could otherwise have been prevented or better managed at the outset. A corollary to this is lack of patient compliance with prescribed regimens for the majority of health care that happens between doctor visits, which also adds to greater use of medical services. According to the Centers for Disease Control and Prevention, chronic diseases such as asthma, cancer, diabetes and heart disease account for more than 75 cents of ever dollar we spend on health care in this country.[9] Although there are no easy solutions to these trends, employers, through their insurance offerings, are helping to lead the way in the delivery of innovation and health care quality initiatives. For example, spending in the employer setting on health promotion, wellness and chronic disease prevention has yielded considerable dividends in reduced health care costs. Programs have achieved a rate of return on investment ranging from $3 to $15 for each dollar invested, with savings realized within 12 to 18 months.[10]

Moreover, the problems of overutilization of medical care services and the disconnect between most American consumers and the cost of the care they receive is not a problem that is limited to those who have group health insurance coverage. These issues are present in all health insurance markets because all traditional health insurance claims are paid by a third party. In fact, one could argue that overutilization may be more prevalent in the individual market, because individual market consumers are more likely to want to "use" their benefits to justify their direct premium expenditures.

NAHU maintains that a preferable way to help curb excessive utilization and claims, as well as moderate costs by increasing competition among providers, is by providing more transparency and disclosure of health care prices and quality, and by increasing access to

---

[7] Peter Cunningham and Laurie Felland, "Falling Behind: Americans' Access to Medical Care Deteriorates, 2003-2007," Center for Studying Health System Change, Tracking Report No. 19, June 2008.

[8] Karen Davis, "Paying for Care Episodes and Care Coordination," *New England Journal of Medicine*, Volume 356: 1166-1168, March 2007.

[9] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. Chronic Disease Overview page: http://www.cdc.gov/nccdphp/overview.htm#2.

[10] David Anderson, Seth Serxner, Daniel Gold, "Conceptual Framework, Critical Questions and Practical Challenges in Conducting Research on the Financial Impact of Worksite Health Promotion," *American Journal of Health Promotion*, May/June 2001, 15(5):281-295.

consumer-directed health insurance products, both in the individual and group health insurance markets. Our health system would certainly benefit if health insurance consumers in both markets were more aware of the cost and quality of the health care that they are purchasing.

We know that American consumers and patients respond favorably to incentives, and that they are increasingly conscious of health care prices. From the growth of lower cost and more convenient retail clinics, to the increasing trend of medical tourism, we seek out the best deal for the best quality. NAHU strongly encourages health insurance carriers, as well as hospitals, physicians and other health care providers to provide better access to the prices they pay and charge for care to all consumers. NAHU would also support legislative and regulatory efforts at the state and federal levels to require increased transparency, should voluntary efforts fail, provided that such governmental efforts are not overly burdensome.

Curbing excessive utilization and claims can also be achieved through expansion of consumer-directed health insurance plans. While not suitable for everyone, these products provide appropriate financial incentives for enrollees to be more aware of costs, and to use information available on cost and quality in making purchasing decisions. To the extent that consumers have more control over their health care dollars, many believe that they can become more efficient users by delaying or forgoing care that may be of low marginal value.

Tax Equity

Although the goal of tax equity for individual market health insurance buyers is certainly laudable and one that NAHU supports, there are several reasons why removing or capping the tax exclusion to help achieve this may need further evaluation in light of the realities of health insurance markets and the absence of preferable pooling mechanisms in the non-group market.

First, group health insurance rates vary significantly by state and are impacted by a wide variety of factors beyond plan design or comprehensiveness of benefits, including state rating laws and other requirements such as mandates. Health insurance prices are also driven by factors such as geography, industry and the age and health status of participants (i.e., composition of the insured group). Some employers pay higher rates than others, and employees and employers often have no control over the difference in rates they are charged. The price of a high-end plan for employers/employees in one state may be the same price or less than the cost for a much more modest plan for a different employer elsewhere. Thus, under the regime of some cap on the exclusion, individuals could incur additional taxes simply because of the health status of the population of the workers in their pool or because of the geographic region in which they live.

Second, in efforts to discourage employees from seeking so-called "Cadillac plans," proposals to revamp the tax exclusion implicitly assume that employees have a choice in employer-provided health benefit plans. However, almost one-half of those covered under ESI have only one plan choice available to them.[11] Health plan participation requirements (which can vary significantly by state and health insurance carrier) and factors relating to administrative costs often result in employers only offering their employees one group health benefits plan option. Moreover, employees do not always have a say in the health plan designs offered by their employers. If the employer-sponsored plan available to an individual

[11] Kaiser Family Foundation / HRET Employer Health Benefits 2006 Annual Survey.

does not meet the cost parameters of some alternative tax preference, individuals may have little or no tax recourse if they want to keep their group health insurance coverage and all of the consumer protections and benefits associated with it.

Proponents of altering the tax exclusion also often make the point that the current tax policy is regressive, citing that workers in higher tax brackets receive greater tax advantages in dollar amounts than those received by lower-paid workers. This occurs because high-income workers face a higher marginal tax rate, and if employer premium contributions were suddenly counted as income, they would realize a greater tax benefit as compared to lower-paid workers. Proponents often suggest limiting or eliminating the tax exclusion for those of higher means (who presumably would purchase insurance without the exclusion) so that tax subsidies might be retargeted to offer extra help to those of lesser means.

This of course begs the question as to which individuals are considered of higher means. By design, revamping the tax exclusion means that the government would be charged with determining at some level what the appropriate amount of health care is. Drawing appropriate lines on income and equity for health care is no easy task, and is complicated further by the fact that costs can vary significantly in different parts of the country. And although some see the current exclusion as an untapped reservoir of revenue that can help address other needs of our health care system, the American public may be skeptical of having some new regime of health care tax policy be susceptible to the political whims and budgetary picture of the day.

In addition, some observers question whether health care and income are always interchangeable, and point out that the exclusion also contains progressive elements that are often overlooked.

There are a number of reasons why health insurance premium contributions from one's employer might not be considered the same as ordinary income. First, individuals enrolling in an employer's health insurance health plan offering are engaging in socially and economically responsible behavior. It benefits society, and it is not as if they are getting something for nothing. Second, the amount of the benefits offered by employers is generally the same for all workers with the same employer, regardless of income (i.e, there is no correlation to wage-related compensation). Third, as a *percentage of income*, the exclusion may also be viewed as progressive because it represents greater savings for lower-income families than for higher-income families. That is, although the exclusion is greater in dollar amounts for families with higher income, as a percentage, the relative amount of tax savings falls as income rises.[12]

Furthermore, it is fairly well documented that individuals tend to prefer employment-based health benefits over taxable wages when given the choice, in part, because of the tax treatment of benefits. When employed Americans with health coverage are asked whether they would prefer $6,700 in employment-based health insurance coverage or an additional $6,700 in taxable income, 80% chose the employment-based health coverage. Two-thirds would prefer employment-based coverage to an increase in income even if an employer paid

[12] EBRI Issue Brief on "The Tax Treatment of Health Insurance and Employment-Based Health Benefits" by Paul Fronstin, No. 294, June 2006. See also Institute of Medicine. "Employment and Health Benefits: A Connection at Risk." Washington, DC: National Academy Press, 1993.

$10,000 toward the coverage. Furthermore, this preference for employment-based coverage emerges regardless of employees' demographic characteristics.[13]

Although the amount of employer premium contribution is generally the same for all employees in a particular firm, critics point to the fact that its relative value under the exclusion is greater for those higher up the earnings spectrum, and that its value is zero for those who have no income tax liability.

Congress has also faced the issue of perceived tax regression in Social Security's payroll tax. In an effort to lighten the burden on working people below certain incomes, Congress introduced the Earned Income Tax Credit in 1975. That is, extra targeted assistance was provided to qualified workers, while the universality of the Social Security program was maintained. In the health insurance world, the exclusion could be made more equitable and progressive with the addition of a targeted refundable tax credit—which could be paid to the taxpayer even if the amount of the credit exceeds the tax liability and which would result in a reduction in taxes for families with no federal income tax liability.

The Tax Exclusion and Employment-Based Pooling Arrangements

Another important issue for policymakers to consider is the effects that a change in the tax exclusion might have on pooling arrangements for employers, and employers' willingness and ability to continue offering job-based health insurance at preferable large group rates.

In terms of insuring a group of individuals, employment-based groups are often considered "natural groups" in the sense that they were formed for reasons other than the purchase of health insurance. Insurers are more willing to provide insurance for a naturally formed group than for a group that was formed solely for the purpose of buying health insurance because the risks of adverse selection are mitigated. And employers are generally willing and able to offer their insurance on a guarantee issue basis and at community rates, meaning that everyone in the employer group, no matter what age or health status, is offered coverage and charged the same premiums.[14]

In a purely voluntary system, such as the American system, the risk of adverse selection is relatively high because those most likely to seek insurance for health care are also those most likely to need health care. As a result, when insuring groups in the employer setting, insurers recognize a generally good mix of insurable risk and know that adverse selection is mitigated because of controlled entry into and exit from the plan by the employer, allowing those individuals the same opportunity to be covered by a health insurance plan. Hence, employment-based health insurance is a potent means for spreading risk among both healthy and unhealthy individuals.[15]

Although broadening health insurance choice is generally considered a positive goal, if a change in the tax exclusion is structured in such a way that workers would have a choice to leave the employer group insurance offerings to pursue individual market policies, there could be changes to the pool of the employer's insured population. Younger, healthier

---

[13] EBRI and Matthew Greenwald & Associates, Inc., 2005 Health Confidence Survey.

[14] EBRI Issue Brief on "Health Insurance and Taxes: Can Changing the Tax Treatment of Health Insurance Fix Our Health Care System?" by Paul Fronstin and Dallas Salisbury, No. 309, September 2007. HIPAA requires that insurance sold in the small group market (2-50 employees) also be issued on a guaranteed issue basis.

[15] *Ibid.*

workers whose health insurance premiums typically might cost less than their alternative tax preference may shift from employer-sponsored to individual coverage. To the degree this occurs, the employer-based market could become a less healthy mix of insurable risk, as sicker, older workers stay with their employer-based coverage while more of the healthier workers move to the individual market. And the exodus of younger and healthier populations from an employer's pool would likely drive up the costs of the employer plan, for both the employer and beneficiary alike. The likely destabilization of group risk pools that could well result raises the question of whether employers would continue to offer health insurance to their workforce.

Building on the Employer-Based System:
Extending Tax Equity for Health Insurance

The issues relating to the Tax Code and health insurance are not unlike those facing Congress in the 1970s when it was looking to expand options for personal retirement savings. Congress did not seek to dismantle a successful employer-based pension system just because all employers did not offer plans. Instead, it created IRAs and other tax- preferred avenues for retirement saving to complement and build upon our ever evolving employer-based pension system.

In a similar vein, why dismantle a successful and essentially popular ESI system and take away employers' incentives to differentiate nonwage-related benefits? As referenced earlier, this is not to say that the employer-based system does not require improvements. But we can fashion tax equity and level the playing field for those outside the employer system in other more targeted, more productive ways. Building on safety net programs, we should use the Tax Code to guarantee that low-income people can afford adequate insurance and that affordable health insurance exists either at work or in a reformed non-group market, without encouraging excessive spending.

ESI need not disconnect consumption decisions from payment responsibilities, nor reduce consumers' incentives to seek out prices and other health information that would facilitate cost-effective decisions. Consumer-directed health insurance options like HSAs, HRAs and FSAs are highly compatible with ESI and are growing in popularity, and NAHU strongly supports enhancing access to these unique health options through tax incentives.

NAHU's membership of more than 20,000 health insurance agents and brokers works every day to help millions of employers and individuals make responsible health insurance purchasing decisions. Our organization is committed on a national level to providing more tools and resources for workers to make more informed decisions about health benefits and health care, and to give people options in terms of purchasing coverage.

We also have organizations like the Leap Frog Group, the Consumer Purchaser and Disclosure Project, the Human Resources Policy Association and the AQA Alliance that are all making significant investments in these areas to help better educate employers and consumers.

ESI is proof that the Tax Code can be used effectively to encourage the purchase of health insurance. Rather than upend the successes of ESI and the current tax exclusion, NAHU

believes that tax incentives for the purchase of health insurance should build on what has worked in ESI and be used in tandem with the current employer system.

NAHU supports efforts to help level the playing field in terms of tax incentives for purchasing health coverage. One way would be to adopt targeted tax incentives and regulatory relief for small businesses to better afford health insurance offerings. Under current law, the self-employed health insurance deduction is not considered an ordinary and necessary business expense, as it is for the corporate entity, and thus premiums are still subject to the self-employment (FICA/payroll) tax. A good step in the right direction would be to equalize the self-employed health insurance deduction to the level corporations deduct, by changing it from a deduction to adjusted gross income, to a full deductible business expense on Schedule C.

A refundable, advanceable and assignable individual health care tax credit would give uninsured Americans direct financial assistance with their monthly health insurance premiums, making them more affordable. A refundable credit would ensure that even uninsured people who owe no taxes are eligible for assistance. An advanceable credit would ensure that the uninsured receive the credit when premium payments are due, and not require them to wait until the end of the tax year for reimbursement. An assignable credit would allow the uninsured to have their credit sent directly to an insurer of choice or to their employers if they get coverage through the workplace. This would reduce burdensome accounting paperwork and leave individuals with only the remaining premium balance, if any.

NAHU believes that a refundable tax credit is preferable to a tax deduction. A look at the roster of uninsured individuals today reveals that most are moderate to lower income workers, and nearly half of the uninsured have no income tax liability.[16] Unfortunately, for these individuals, a tax deduction offers little incentive beyond what is already available. Because they do not owe income tax, they do not get a deduction other than the amount they are paying for payroll tax. Although this is helpful, it is unlikely to be enough to enable them to afford health insurance coverage.

Congress might also seek to remove the 7.5% of adjusted gross income limit of medical expenses on tax filers' itemized deduction Schedule A form, and to allow the deduction of individual insurance premiums as a medical expense.

Tax incentives for the purchase of health insurance outside of the employment-based system in this manner would also help address another common criticism of ESI— namely the perceived lack of portability of one's health insurance at the end of employment with a firm that offers it. Such tax incentives can also help address what is colloquially referred to as "job lock," or instances where individuals or families feel they must remain in a less-than-desirable job where one is offered insurance because they could not otherwise afford it.

Policymakers may also want to consider additional reforms to the nonlarge-group market for enhancing the accessibility of insurance with any additional tax incentives. The issue of pre-existing conditions and individual market coverage portability has been repeatedly identified as a problem with our nation's individual market coverage system. People who have

---

[16] "Health Savings Accounts and High Deductible Health Plans: Are They an Option for Low-Income Families?" (#7568), The Henry J. Kaiser Foundation, October 2006.

obtained individual coverage when healthy and then acquired a medical condition can be limited in their options for switching coverage plans, due to preexisting condition and medical underwriting requirements. However, these very requirements are what helps prevent individual market adverse selection and keeps individual market prices down for the entire insured population. Texas, for example, addressed this issue a number of years ago in a way that ensures people access to coverage while still preserving affordability in the private market. The state offers individuals who have been responsible and maintained individual market health insurance coverage over time credit for their prior coverage with just a one-month waiting period.

The Road Ahead

Although there are many issues surrounding the Tax Code's support for expanding access to quality private health insurance, NAHU urges policymakers to preserve and strengthen what has worked for group health insurance under ESI, and to build on that by pursuing creative and equitable remedies to fill our remaining gaps in health care access while preventing new gaps from expanding. A constructive debate over revamping the federal tax treatment of health care must address not just what a new system might seek to accomplish, but also what tradeoffs and unintended consequences might be, and who would be likely to be most affected by any changes.

Far from being some relic of a bygone era, employer-based insurance supported through the current tax exclusion is responsible for many of the innovations in insurance coverage in recent years, with employers directing their insurance carriers to develop and implement many enhancements in the health care arena. This includes wellness and health promotion initiatives, high-performance networks, pay-for-performance, tiered cost sharing for prescription drugs, centers of excellence, value-based benefit designs and HSAs.[17]

Providing equitable tax treatment of all health insurance purchasers is a worthy goal that would help foster and facilitate additional innovations and experimentations for expanding insurance coverage on the state and local levels.

The most promising approach involves building on ESI while slowing the growth of overall systematic health care costs. The expansion of consumer-directed health care plans for instance that rely more on tax-advantaged personal saving earmarked for health expenses—both in conjunction with the employer setting and outside of it— can help individuals better assess the cost and quality of the choices they make in health care.

Removal of tax inequities for health insurance would increase the American public's confidence in the operation of competitive markets in health care and private insurance. As NAHU is really at the center of "helping to make health care happen" in America, we stand ready to serve as a resource to policymakers to help answer these important questions so that we can achieve better tax incentives for making private health insurance more affordable and accessible for all Americans.

---

[17] Paul B. Ginsburg, "Employment-Based Health Benefits Under Universal Coverage," *Health Affairs*, Vol. 27, No. 23 (May/June 2008).

APPENDIX A: NAHU's HEALTHY ACCESS PROPOSAL

NAHU believes that any sustainable national health system reform should control the growth in medical spending and guarantee access to affordable coverage for all Americans. We maintain this can be accomplished without limiting the people's ability to choose the health plan that best fits their needs and ensures them continued access to the services of independent state-licensed counselors and advocates. NAHU's Healthy Access proposal is a comprehensive approach to meeting this challenge, and a yardstick for evaluating other proposals.

CONSTRAINING MEDICAL COSTS

Comprehensive health reform initiatives need to address the true underlying problem with our existing system: the cost of medical care. We feel that the following recommendations would make important improvements to the U.S. health care system to lower costs, improve quality and create greater efficiency:

Behavior and Lifestyles Recommendations

- Require federal and state governments to incorporate wellness and disease-management programs into medical programs for employees and government-subsidized health coverage.
- Provide employers with legal protections and tax and premium incentives for wellness programs.

System Inefficiencies Recommendations

- Provide incentives for doctors and medical facilities to improve system efficiencies and eliminate errors with pay for performance, best-practice guidelines and support for evidence-based medicine.
- Create federal standards for interoperable electronic medical record technology to help unify the health care system, reduce errors and improve patient satisfaction.
- Enact comprehensive medical malpractice reform that limits non-economic damage awards, allocates damages in proportion to degree of fault, places reasonable limits on punitive damages and attorney fees, and imposes reasonable statutes of limitations on claims. Encourage state authorities to increase the effectiveness of discipline imposed on incompetent doctors.

Cost-Shifting Recommendations

- Reimburse providers participating in all federal health care coverage programs, including Medicaid, Medicare and SCHIP, at the same level paid to providers serving federal employees through the Federal Employees Health Benefit Plan.
- Encourage states to streamline the application processes for public health insurance programs like Medicaid and SCHIP, and allow for presumptive eligibility, so that all eligible participants are enrolled and their providers are paid instead of incurring uncompensated care expenses.

Decreasing Utilization Recommendations

- Encourage expansion of consumer-directed health insurance products.
- Make consumers fully aware of the cost of the health care that they are purchasing by enabling and encouraging health plans and providers to overcome policy concerns (e.g., prohibiting gag provisions in provider contractors) and bring complete price information to the public as soon as possible.

ACCESS FOR ALL

All Americans should have access to affordable health care coverage. As important as affordability, however, is choice. There needs to be choice of providers, choice of payers and choice of benefits, with many price and coverage options. The reality is that we are a diverse nation with diverse needs. One size does not fit all when it comes to health care.

Guaranteed Access to Health Insurance Coverage in Every State Recommendations:

- Right now, in a number of states there are people with serious medical conditions and no access to employer-sponsored health insurance; they cannot buy health insurance at any price. Most states, but not all, have independently established at least one mandatory guaranteed purchasing option, the most common and effective of which is a high-risk health insurance pool. The federal government should

require that all states have at least one private guaranteed purchasing option for all individual health insurance market consumers.

- The federal government should provide seed grants to states creating high-risk pools and states that provide risk-pool premium subsidies to low-income citizens and older beneficiaries (who tend to be charged the highest rates) to help ensure continued coverage for early retirees.

Reinsurance Recommendation:

- Making it easier and more affordable for carriers to reinsure expenses related to extraordinary claims could prove to be an effective way of lowering premiums. In considering reinsurance as part of an overall reform package, Congress should conduct a study to thoroughly analyze the efficacy of reinsurance programs.

Affordable Access Grants to States Recommendations:

- States should be encouraged to create regulatory climates that ensure the availability of many affordable coverage options, and should offer premium subsidies to targeted populations in need of such support. The federal government should make block grants available to states to encourage and reward health insurance innovations that utilize the strengths of the existing private marketplace.

Tax Equity Recommendations:

- The vast majority of privately insured Americans receive their health insurance coverage through their employer or the employer of their spouse or parent. The preservation of the federal employer tax deduction and employee exclusion is critical.
- But the employer-sponsored health insurance system does not work for everyone. As such, federal tax laws should be updated to provide the same tax deductions to individuals and the self-employed that corporations have for providing health insurance coverage for their employees.
- Congress should remove the 7.5 percent of adjusted gross limit of medical expenses on tax filers' itemized deduction Schedule A form, allow the deduction of individual insurance premiums as a medical expense, and equalize the self-employed health insurance deduction to the level corporations deduct by changing it from a deduction to adjusted gross income to a full deductible business expense on Schedule C.
- The federal requirements regarding individual policies sold on a list-bill basis— whereby the employer agrees to payroll-withhold individual health insurance premiums on behalf of its employees and send the premium payments to the insurance carrier but does not contribute to the cost of the premiums— need to be clarified regarding the establishment of Section 125 plans, HIPAA group insurance protections, and the applicability of state-based individual health insurance laws and regulations.

Public/Private Producer Community Education Partnership Recommendations

- All health insurance consumers, both private and public, should have access to quality information and assistance regarding their health care coverage. NAHU will assume responsibility for training insurance agents in all coverage options, both public and private, through the creation of a designation program— the Certified Health Care Access Advisor.

FINANCING ACCESS

Many of the Healthy Access recommendations, particularly those concerning controlling our nation's rising health care costs, will actually save both state and federal health care dollars. Despite these substantial savings, eliminating public-program cost-shifting and ensuring access to affordable private health insurance will likely result in the need for increased public funds. NAHU feels such funds should generally be derived from assessments on activities that drive health costs higher. Assessments that encourage healthy and cost-effective behaviors while discouraging unhealthy and cost-ineffective ones will result in both additional funds and healthier citizens.

The Importance of the Current Tax Treatment of Employer-Sponsored Health Coverage for Employees

Statement of
The National Business Group on Health

Prepared for the

Committee on Finance
United States Senate
Hearing on Health Benefits and the Tax Code: The Right Incentives

July 31, 2008
Washington, DC

For questions or comments, please contact Helen Darling, President or Steve Wojcik, Vice President of Policy at
The National Business Group on Health • 50 F Street, NW • Suite 600 • Washington, DC 20001
Telephone: 202.628.9320 • Fax: 202.628.9244 • email: policy@businessgrouphealth.org

The National Business Group on Health (Business Group) commends the Senate Finance Committee for its ongoing series of hearings on health reform, including its recent Health Reform Summit, and appreciates the opportunity to submit written testimony on the importance of the current tax treatment of employer-sponsored health coverage to employees, employers, and to our country as it seeks more affordable, effective and efficient health care.

Founded in 1974, the Business Group is a member organization representing 300 members, mostly large employers, who provide coverage to more than 55 million U.S. employees, retirees and their families and is the nation's only non-profit organization devoted exclusively to finding innovative and forward-thinking solutions to large employers' most important health care and related benefits issues. Business Group members are primarily Fortune 500 companies and large public sector employers, with 63 members in the Fortune 100.

With escalating health costs, increasing awareness of quality and safety gaps and growing numbers of uninsured, the need for health care reform is at an all-time high. Successful health reform, however, is a daunting but critical challenge that will require everyone—individuals, health care providers, suppliers, insurers, employers and governments at all levels to share responsibility and do their part.

As you know, today, employers are the principal source of health coverage for non-elderly people in the United States, voluntarily providing health benefits to about 161 million Americans.[1] In other words, the most recent data show that more than 60 percent of the population under age 65 is currently covered by employment-based plans.[2]

Employers provide health coverage for active employees, their dependents and retirees on a voluntary basis either directly by setting up self-insured employer plans or by purchasing coverage through insurance companies. The decision to provide health coverage, the level and scope of benefits, and the amount of money that employers contribute to their employees' health care depend on a number of factors including employee health and productivity improvement; the needs and preferences of employers' workforces; as a recruiting tool to attract and retain the best talent; labor market conditions; economic conditions; company growth and profitability; the relative cost of health and other benefits; and the tax advantages, which play a very important role.

Under current tax rules, employers can deduct their contributions for employees' health care from corporate income just as they deduct employees' wages and salaries as ordinary business expenses. Simultaneously, employees can exclude the value of these contributions from their income for tax purposes. They can also use pre-tax dollars to pay for their share of health premiums and often use pre-tax

[1] Fronstein, Paul and Dallas Salisbury. Health Insurance and Taxes: Can Changing the Tax Treatment of Health Insurance Fix Our Health Care System? EBRI. September 2007.
[2] Ibid.

dollars for their out-of-pocket health expenses through flexible spending accounts (FSAs) offered by their employers.

The Federal government has consciously used tax policy for a long time to promote health coverage and the Business Group believes that the current favorable tax treatment of employer-sponsored coverage is a key reason that so many families have affordable coverage. This policy helps employers provide more comprehensive health benefits at a lower cost to employees and their dependents.

This testimony will highlight the key role of the current tax policy and employer-sponsored health coverage in assuring coverage for so many Americans and improving the effectiveness and efficiency of health care.

This written testimony covers four main points:

1. **The importance of the tax exclusion and employer-sponsored coverage to employees.**
2. **The importance of the current tax treatment for employers.**
3. **The important role and contribution of employer-sponsored health plans.**
4. **The role of the tax treatment of employer-sponsored coverage's impact on the number of uninsured.**

1. THE IMPORTANCE OF THE TAX EXCLUSION AND EMPLOYER-SPONSORED COVERAGE TO EMPLOYEES

- **Tax Advantages Help Make Health Care More Affordable for Employees**

Employees pay less for more comprehensive benefits through employer-sponsored coverage. The lower price encourages more employees to take up coverage for themselves and their families. For some employees, the tax advantages make the difference between taking up their employers' coverage and declining coverage because it is too expensive. Younger, healthier employees elect to participate in employer-sponsored coverage because the personal tax exemption for benefits, along with their employers' tax-deductible contribution, makes the coverage more affordable. Many are at the lower income levels when just beginning their families and careers; their first priority is typically net pay. These employees frequently do not have an immediate expectation of requiring health care and in fact may only occasionally utilize the coverage. They participate primarily because health care benefits are so heavily subsidized by employers and there are no adverse personal tax consequences.

- **Employees Value Employer-Sponsored Coverage**

Employees and job candidates expect and value health benefits as a key part of their employment and compensation. Seventy-five percent of employees in a survey commissioned by the National Business Group on Health considered their employment-based health plan their most important benefit and 83 percent said they would rather see their salary or retirement benefit reduced over their health benefit. About three out of four employees (75 percent) who responded to the survey said they would prefer to continue obtaining health benefits through their employer rather than receiving additional salary to purchase benefits on their own[3] (a copy of the survey is attached).

[3] Greenwald, Matthew and Associates. National Business Group on Health Employer-Based Health Benefits Survey. April 2007.

Other surveys have similarly found that employees highly value health coverage through their employers. A recent Kaiser Family Foundation Health Tracking Poll found that when people who are currently covered through their employers were asked for their initial reactions to buying health insurance on their own, 63 percent said it would be harder to find a plan that matches their needs as well; 64 percent said they would find it harder to handle administrative issues such as filing a claim or signing up for a policy; 80 percent said they would find it harder to keep health insurance if they were sick and 81 percent said they would find it harder to get a good price for health insurance.[4]

- **A Majority of Employees Oppose Taxing Employer Health Care Contributions**

A statistically valid survey conducted last year by Matthew Greenwald & Associates for the Business Group of over 1,600 employees with employer-sponsored coverage found that **the majority of the employees, 57 percent, oppose treating employers' contributions to health plan premiums as taxable income, while only 30 percent favored this change.**[5]

2. THE IMPORTANCE OF THE CURRENT TAX TREATMENT FOR EMPLOYERS

- **Current Tax Advantages Encourage Employers to Offer Coverage**

The tax-favored status of employer-sponsored coverage encourages more employers to offer health benefits because it lowers their costs. While the percentage of employees with employment-based coverage has fallen 8 percent since 2001, primarily because of escalating costs, an average of 60 percent of employees still had employer-sponsored coverage in 2007.[6] The tax advantages help to offset part of the costs.

- **Current Tax Advantages Encourage Employers to Offer More Comprehensive Coverage**

In many cases, employment-based coverage provides a broader scope of benefits and more comprehensive coverage than is available or affordable with individually-purchased insurance.[7] The current tax status of employer-sponsored coverage encourages employers to offer more comprehensive benefits for employees. Examples of employer investments in health benefit programs include health coach availability to both healthy and unhealthy employees; health risk assessments; health promotion educational campaigns; richer preventive care; enhanced wellness programs; innovative disease management programs; no-cost, on-site health screenings; and provider health plan scorecards.[8]

---

[4] Kaiser Family Foundation. Kaiser Health Tracking Poll: Election 2008. Conducted June 3-8, 2008. Available at: http://www.kff.org/pullingittogether/062608_altman.cfm

[5] Greenwald, Matthew and Associates. National Business Group on Health Employer-Based Health Benefits Survey. April 2007.

[6] Kaiser Family Foundation. Kaiser/HRET Survey of Employer-Sponsored Health Benefits. 2007.

[7] Agency for Healthcare Research and Quality. Employer-Sponsored Health Insurance. Trends in Cost and Access. September 2004.

[8] Fronstein, Paul and Dallas Salisbury. Health Insurance and Taxes: Can Changing the Tax Treatment of Health Insurance Fix Our Health Care System? EBRI. September 2007.

- **Current Tax Advantages Help Employers Pass Cost Savings on to Employees Through Lower Cost Sharing and Premiums/Premium Equivalents**

The favorable tax status of employer-sponsored health benefits makes it easier for employers to keep employees' costs lower—in all aspects of coverage (i.e., premiums/premium equivalents, deductibles and co-payments, coinsurance, prescription drug, cost-sharing, maximum out-of-pocket expenses, etc.). Employers pay the bulk of the costs for employees' health benefits, which are heavily subsidized. On average, employers paid 84 percent of employees' coverage costs and 72 percent of family coverage in 2007.[9] Some employers pay 100 percent of the employee and family premiums to ensure that every employee has access to health coverage. Others lower employees' costs if they choose high-performing health plans and still others eliminate cost-sharing when employees choose in-network health care providers.

3. THE IMPORTANT ROLE AND CONTRIBUTION OF EMPLOYER-SPONSORED HEALTH PLANS

- **Employers Increase Coverage By Keeping It Affordable for Employees**

Many people with employment-based coverage are covered under highly subsidized employer plans, which are less expensive for employees. As stated earlier, on average employers pay about 84 percent of the cost for the average single coverage plan (over $4,000 per year) and 72 percent of the cost for the average family plan (over $12,000 per year)[10] to ensure that their employees have affordable coverage. The full price is simply too high for low-income employees and even people with higher incomes without substantial employer subsidization.

- **Employer Plans' Natural Risk Pools Provide Advantages for Coverage**

Employment-based health coverage is also successful at spreading risk between the healthy and the unhealthy and between younger and older people. Pooling together risk under employer-sponsored coverage ensures that higher-risk, older or unhealthy individuals are not singled out and that the same level of coverage is provided for all plan members at similar costs. Employer plans' natural risk pools also reduce adverse selection by providing coverage automatically upon employment, requiring new employees to opt out only if they have alternative coverage or by giving new employees a short time period to enroll (typically 1 month by statute) before they become ineligible. These mechanisms reduce adverse selection because people make coverage decisions independent of their need or expected need for health care.

---

[9] Kaiser Family Foundation. Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2007.

[10] Claxton, Gary. Et. al. Employer Health Benefits 2007 Annual Survey. Kaiser Family Foundation. 2007: Kaiser Family Foundation. Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2007.

- **Employers Leverage Their Negotiating Power to Strike Better Deals for Employees' Health Care**

Because employer plans bring groups of people to health plans, in some geographic areas they are a dominant source of payment, they use their negotiating leverage with providers and insurers by bargaining for group discounts for employees, arranging prompt pay discounts with providers, serving as advocates for employees in coverage disputes, requiring quality improvements and obtaining more value for their employees' money than employees could do on their own. For example, insurers are more likely to respond to employers' requests to improve their offerings than to requests from individual plan enrollees who are unsatisfied with their current coverage because of the risk of losing a large group contract.[11]

- **Employers Continue to Be a Source of Health Care Innovation**

Employers believe that there is a strong business case for offering health benefits to employees and they continue to invest in improving their health programs. Many large employer members of the Business Group are already using their market power to demand greater health care efficiency and quality from providers in addition to launching their own efforts to improve employees' productivity and health status. Some examples of employer initiatives include promoting quality assessment of providers; health risk assessments; offering health promotion and disease prevention programs; using care coordination; utilizing disease management and wellness programs; improving the use of primary and preventive care; and promoting the patient-centered medical home.

- **Employers' Economies of Scale Lower Administrative Costs for Employees' Coverage**

Employer-sponsored health benefits create significant administrative efficiencies, that keep more employers' and employees' dollars available to pay for medical costs. Lower administrative costs help keep employees' premium equivalents lower and enable employers to offer more benefits. Overhead costs for the largest employer groups are typically 5 percent or less, whereas these costs reach around 20 percent for smaller groups and goes above 30 percent for purchasers of individual insurance.[12] Savings of this magnitude allow employers to provide more extensive coverage for employees that otherwise would not be made available.

4. THE ROLE OF THE TAX TREATMENT OF EMPLOYER-SPONSORED COVERAGE'S IMPACT ON THE NUMBER OF UNINSURED

Many families would simply find health coverage unaffordable if they were taxed on their employers' portion of their health care costs and/or they were unable to use pre-tax dollars to pay their premiums and out-of-pocket expenses under employer-sponsored plans. In particular, younger and healthier employees could opt out of their employer coverage. The current tax advantages of employer-sponsored coverage is a

---

[11] Fronstein, Paul and Dallas Salisbury. Health Insurance and Taxes: Can Changing the Tax Treatment of Health Insurance Fix Our Health Care System? EBRI. September 2007.

[12] Hall, Mark. The Geography of Health Insurance Regulation: A Guide to Identifying, Exploiting, and Policing Market Boundaries, 19, Health Affairs. Mar.-Apr. 2000.

major factor that makes it significantly more attractive for younger people to purchase coverage through their employers. Removing the ability of employees to pay their premiums with pre-tax payroll deducted earnings and/or imposing a tax burden on them for their employers' contribution toward their health care plan costs would result in a significant number of employees simply discontinuing their coverage, causing a increase in anti-selection in employers' plans, a decrease in their ability to cross-subsidize, and subsequent cutbacks in health care benefits offered. Some employers might also choose to stop offering health care benefits in light of the resultant escalation in costs, decrease in morale among their employee population, etc.

Studies by the Urban Institute-Brookings Tax Policy Center and the National Bureau of Economic Research (NBER) estimated that eliminating the tax exclusion of employer health care contributions from income and payroll taxes would reduce employer health benefit offerings by 17 to 30 percent, and would decrease employer premium shares for those who continue to offer coverage by 30 to 42 percent.[13] The study by the NBER also found that smaller employers would be more likely to stop offering coverage if the tax exclusion were eliminated and larger employers would be more likely to cut back on the amount they subsidize, both of which would increase the number of the uninsured substantially.

The favorable tax status of employer-sponsored coverage plays an important role in keeping employer risk pools intact so they are able to cover people of every age group and health status. Depending on the industry and labor market conditions, some employers who continue to offer health care at the same level could see increased labor costs as they are pressured to compensate employees for their higher tax payments. Finally, if health benefits were taxed, benefits such as pensions and other nontaxable benefits could be taxed in the future, which would make them more costly for employers and employees and they could potentially be eliminated or reduced.

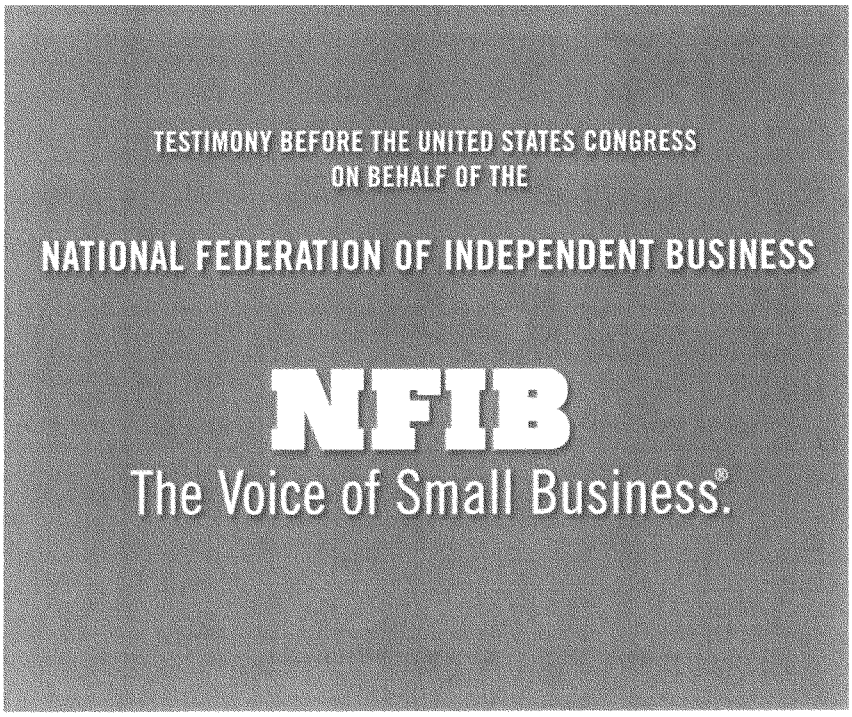
CONCLUSION

Rather than changing the tax status of employer-sponsored coverage, which provides health care benefits to the vast majority of non-elderly Americans, the Federal government should step up efforts to use its leverage as the largest purchaser of health care and work with employers, providers and health plans to provide solutions to the rising costs and the poor and uneven quality of health care. CMS' recent initiative to stop hospital payments for "never events" to improve the quality of care in the Medicare program is an example of the type of initiative and leadership that will go further to improve the effectiveness, efficiency, and affordability of health care rather than changing the tax code.

Mr. Chairman, thank you and the Committee for this opportunity to share the National Business Group on Health's perspective on this important issue. Changing the tax status of employer-sponsored coverage would only increase health care costs for 161 million employees and their families. The vast majority of employees in employer plans, 57 percent, are opposed to being taxed on their employers' contributions to their health care coverage. The Business Group looks forward to working with the Congress to preserve and protect this important benefit to ensure that employers can continue to provide the health care benefits that Americans want, need and deserve.

---

[13] Burman, Leanord. Et al. Tax Incentives for Health Insurance. Discussion Paper 12. The Urban-Brookings Tax Policy Center. May 2003.: Gruber, Jonathan, and Michael Lettau. How Elastic Is the Firm's Demand for Health Insurance? NBER Working Paper 8021. National Bureau of Economic Research. 2000.



Statement for the Record

National Federation of Independent Business (NFIB)

for the

Senate Finance Committee

on the subject of

Taxation of Healthcare Benefits

on the date of

July 31, 2008

Thank you for holding this hearing on the taxation of healthcare benefits. The current exclusion of employer-provided health benefits from taxation plays a significant role in the structure and delivery of health insurance. As the Committee continues to examine issues surrounding health insurance, it is important to consider the implications current tax treatment has on healthcare.

In the 1940s, wage and price controls propelled lawmakers to react by allowing businesses to offer health insurance as part of employee compensation and to exclude the cost of those benefits from tax. As the single largest federal tax subsidy – more than $200 billion – this unintentional tax break has had an influence on the development of the healthcare market. Most notably, the exclusion has tied the connection of healthcare benefits to the workplace with more than 160 million nonelderly individuals receiving healthcare through their employer. In addition, the exclusion has created an "invisible" tax benefit that few employees realize they are getting and that helps to disguise the real cost of healthcare. The exclusion also encourages over-insuring that leads to distortions in the market.

This connection between the workplace and healthcare benefits creates unique challenges for America's small businesses. With the cost of insurance for small businesses rising every year in double digits, it's no wonder more than 28 million of the 47 million uninsured Americans own or work for small businesses. Access to affordable healthcare continues to rank as the top problem and priority for small business.

Because of the large impact the exclusion of health benefits has on the current health care market, Congress should examine possible adjustments to the exclusion as part of the healthcare debate. Creating the right balance between the tax treatment of health insurance benefits with incentives for the employer and employee can help to address some of the inefficiencies created under the current system.

Capping the exclusion could help end the distortions created by the current tax subsidy. A more transparent market for health insurance would encourage smarter healthcare consumption with individuals paying closer attention to the true cost of health insurance and matching those costs to their actual healthcare needs. By including the right balance of tax credits with such a proposal, Congress could create a more dynamic individual and small group market with new incentives for individuals to shop for health insurance. The right solution could also provide the self-employed with equal healthcare incentives and end the disparity in the tax treatment of health insurance for the self-employed.

It is important for Congress to consider other areas of reform, specifically the small group market and how it directly relates to this hearing's discussion. Certain efficiencies are created through employer-sponsored insurance and those efficiencies, such as simplified enrollment and paperwork, should be supported. While such administrative efficiencies are encouraged, the small pools created within the workplace as a result of the tax exclusion can lead to adverse consequences in the small business market. A large firm can better sustain a health risk within their workforce than a small firm, which can see their annual costs rise dramatically. Only addressing the tax treatment of healthcare

could lead to more problems in the delivery of health insurance to small business owners and their employees. That's why it necessary for Congress to also reform the small group and individual markets and create additional pooling arrangements for small businesses.

In addition, the exclusion of health insurance from taxation creates a tax inequity for self-employed individuals. Until recently, self-employed individuals did not receive any of the advantages the tax code provides relative to employer-sponsored insurance. Congress addressed part of this problem by creating an individual tax deduction for the cost of self-employed healthcare plans. This deduction has started to level the playing field between the self-employed and others, but they continue to pay payroll taxes equal to the value of their health insurance.

Short of capping the exclusion, the Committee should consider S. 2239, the Equity for Our Nations Self-Employed Act, introduced by Senators Bingaman and Hatch, which would address the disparity in tax treatment for self-employed individuals. Technology has provided more workers with the tools to start their own business, but we should not stifle the entrepreneurial spirit by locking these individuals into their workplace to keep their insurance. Creating tax equity is a small step that Congress can take to reduce the cost of health insurance and level the playing field.

We appreciate the Committee's interest in this important topic. Examining all aspects of the healthcare market is an important step in crafting a workable solution to decrease the number of uninsured Americans and to reduce the cost of health insurance. Healthcare reform is the NFIB's number one priority, and we look forward to working with the Committee to find a solution that will help to solve the biggest problem impacting small business owners and their employees.