Tax Treatment of Health Insurance: A Primer
Alliance for Health Reform
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ED HOWARD, J.D.: —the abstract that sounds like a pretty subject, but there are, I suggest, 200 billion or more reasons why it ought to peak your interest. Those reasons, of course, are dollars. That's roughly the size of the tax preference for employer-sponsored health insurance, and probably an important reason why so many of us get our health coverage through our jobs or the job of somebody in our family.

This tax preference has become a little less obscure over the course of the last few months of presidential campaign. It has been the subject of some attack ads and defense ads and commentary. People are questioning whether the current tax policy is the wisest one, as we look to reform our healthcare system in general, which, in turn, raises the question, what is the current tax policy toward health insurance?

It turns out that the answer to that question is pretty complicated. That brings us to today's program. We're going to look at how the system works now, what its strengths and weaknesses are, and the kinds of proposals for change that have been put forward by a range of analysts and advocates and policy makers. We hope it will be of service to you as this debate continues.

Our partner in today's program is the Kaiser Family Foundation, one of the most respected policy voices in the reform debate and, in fact, in all of the discussions of policy issues around the healthcare topic. Not so coincidentally, we have Larry Levitt of the foundation with us today. As you see, we have only two speakers, as we try to maximize your chance to ask questions and broaden your understanding of this important issue.

We didn't rehearse this in advance, but, Larry, would you like to say a few words on behalf of the foundation up front?

LARRY LEVITT: Sure. As Ed said, our role is really to inform debates, and it looks like we are potentially about to have a debate on some of these issues, so this it exactly the kind of thing that we aim to do.

ED HOWARD, J.D.: Thanks very much. Let me just alert our speakers to something that everybody in our audience is aware of, and that is that this beautiful room has lousy acoustic, so if you will try to speak perhaps a bit more slowly and distinctly and into the microphone than you might ordinarily do, I think everybody will appreciate that. I will try to remember it myself.

I have a couple of logistical notes. By Monday, I think, you can view the webcast of this session on www.kaisernetwork.org. We could ask if that's true of the

editor-in-chief of Kaisernetwork.org, on my right. In a few days, both on that website and on the Alliance website, www.allhealth.org, you'll be able to read a transcript and look at the materials—actually, the materials are there now—that you have in your packet, so you can share them with folks.

In those same packets, you'll find green question cards and blue evaluation forms, which I hope you will invoke at the appropriate time. So, if you would take just 15 seconds to turn off your cell phones and pages, we will turn to our program.

We're going to lead off this afternoon with Larry Levitt. I noted that he is with the Kaiser Family Foundation, where is a Vice President and the Editor-in-Chief of Kaisernetwork.org. And if you haven't discovered that wonderful resource, make a note to do so when you go back to your office. You can sign up to receive their Daily Health Policy Report. It'll make you sound like an insider, even if you're not an insider, like some of us are not insiders.

He's done a stint at the respected health consulting firm, the Lewin Group. Larry was a Senior Health Policy Advisor at HHS during the Clinton years, worked on cost containment—he headed the Cost Containment Task Force—of the President's Health Reform Task Force. We're very pleased to have him do your basic briefing about what the current state of

the tax treatment of health insurance really is. Larry, thanks for joining us.

LARRY LEVITT: Thanks, Ed. Well, complicated and dry is always the way a speaker wants to be introduced, right? But fortunately I'm not a lawyer or a tax accountant, so maybe I'm perfectly situated to make sense of some of the arcane ways in which the tax system subsidizes healthcare.

As Ed indicated, this is meant as kind of a whirlwind tour through the tax system, so I will undoubtedly gloss over details, but I think we have plenty of time for questions and answers at the end, so we can fill in any holes then.

Broadly speaking, there are two kinds of tax subsidies for healthcare. One category of subsidies provides assistance for health insurance, primarily employer-provided health insurance. The second category provides subsidies for out-of-pocket health expenses that individuals have. I'm going to start with this second category, but spend a little bit more time on the first category, since I think it’s both more complicated and also particularly interesting, given the potential healthcare reform debate that’s ongoing.

So, we will start with the subsidies for out-of-pocket spending. I think many of you have heard of health savings accounts, but what I want to do is run through how they actually work.

First of all, to qualify to set up a health savings account, you have to have a high-deductible health insurance plan that you're enrolled in, either you by yourself or that is provided by your employer. The minimum deductible for these HSA-qualified plans is $1,150 for an individual and $2,300 for a family in 2009. Only preventive services, no other services can be provided separate or exempt from this deductible.

Now, a key distinguishing feature of health savings accounts is that either employers or individuals can then make tax-free contributions to these health savings accounts that individuals can then use to cover their out-of-pocket expenses. The health savings account itself, regardless of whether the employer makes contribution, is owned by the individual and the individual can carry it from job to job and balances roll over from year to year.

These HSA plans and HSA accounts have growth tremendously in recent years. Over 6 million people this year are in HSA-qualified plans. That is up from 1 million just a few years ago, in 2005. But it still represents a relatively small percentage of the overall insurance market. If you look at employer coverage, people who have health benefits through their employers, just 4-percent of workers are enrolled in what's known as an HSA-qualified plan.

And importantly, not everyone who is in an HSA-qualified plan, one of these high-deductible plans, actually

has a health savings account that goes along with it, because you're not required to set one up.

If you look at employees who are in these HSA-qualified plans, about a quarter of them don't get any contribution to their health savings account itself from their employer, while about a quarter get contributions of $2,500 or more, so a very diverse distribution.

Now, there are also health reimbursement arrangements (HRAs), which sound kind of like HSAs, but they're really quite different. Unlike an HSA, an HRA or health reimbursement arrangement doesn't have to be paired with a high-deductible plan. It can be paired with any type of insurance policy. It also allows tax-free contributions to cover out-of-pocket costs, but, again, unlike HSAs, only employers can make contributions to these HRA plans. Individuals cannot. And the plans are not owned by the individual in the same sense as an HSA is. So, while balances carry over from year to year if you stay with an employer, you generally cannot take an HRA from job to job.

Finally, there are HRAs and HSAs—there's no reason not to have more acronyms—and we have FSAs, too, flexible spending accounts or flexible spending arrangements. These have been around for a quite a while, longer than HSAs or HRAs. They're used by workers—and I think many folks in this room have them—

to make essentially upfront payments out of their own wages in order to cover out-of-pocket costs.

The way this works is if your employer sets up an FSA—and the employer has to set it up; you cannot do it yourself—then you can voluntarily have money taken out of your wages in advance that you can then use to cover out-of-pocket costs. The amounts that are taken out are tax-free. It's deducted from your taxable income.

FSAs are different from HRAs and HSAs. They do not carry over from year to year. They're known as use it or lose it, and you certainly cannot take them from job to job.

Now, the final subsidy for out-of-pocket expenses, tax subsidy, is the deduction that's on the standard tax form. Individuals can deduct health expenses to the extent they exceed 7.5-percent of their income, their adjusted gross income.

It applies to a broad range of health expenses and health insurance expenses an individual might have, but there are several limitations. One is that those expenses have to exceed 7.5-percent of income, which is not true for most people. Only the amount above 7.5-percent of income can be deducted. So if you, let's say, have expenses of 8.0-percent of income, you can only deduct that 0.5-percent. And you must itemize deductions in order to qualify, so someone who's lower income or doesn't itemize wouldn't qualify for this deduction.

Now the complicated stuff—tax subsidies for health insurance. I think many people, when they think of tax subsidies for health insurance they think of the fact that an employer can deduct the cost of health insurance from the corporate income tax or corporate profit tax. That is certainly true. Employers can deduct the cost of health insurance, but that is really like any other business expense, so it's not really a special subsidy for health insurance.

The real subsidies for health insurance comes from the fact that employees do not get taxed on the health benefits provide. So, in other words, when an employer provides wages to an employee, those wages are taxed as income. When an employer provides health benefits to an employee, those benefits are not taxed as income. They're essentially provided tax-free and, in effect, lower the taxes that an employee would otherwise pay.

And this has been true since very early in the century and, in fact, health benefits got a boost in 1943 with the War Labor Board when it ruled that health benefits were exempt from the wage freeze that was put in place, so employers had an incentive to provide compensation to their employees in the form of health benefits, as opposed to wages, which they could not increase.

And then Congress codified this exclusion from the exclusion of health benefits from income in 1954 in the revenue act and put that in place in the tax code.

Now, what I've been talking about excludes the amount employers pay from income. Employees don't automatically get a tax subsidy for the amount they contribute towards health insurance premiums, but there is a mechanism to provide for a tax subsidy for that through what are called section 125 plans. The way these plans work is essentially like a flexible spending account, where, if the employer provides for this, the employee can have the amount of their premium deducted from their wages automatically and have that be done on a tax-free basis, the same you would, let's say, make a contribution to a 401k pension account.

Even though there's really no cost to the employer for doing this, except for an administrative hassle, not all employers do. Virtually all large employers do this, about 92-percent, but only about 60-percent of small businesses provide this mechanism.

There's also a deduction for self-employed people for their health insurance premiums, but, as you'll notice, there's really nothing in the tax system to speak of that provides a subsidy for individuals buying insurance on their own, if their employer doesn't provide it. That's one of the key issues that we'll be talking about.

Now, I want to work through—hopefully you can see this or you have it in your packet—a couple of examples of how this works, which I think will make things a little clearer.

What I have here is a modest-income family with one wage earner. We'll call her Jane. Her husband Joe is a plumber, but he got laid off, so he's a stay-at-home dad. They have wages of $50,000. You'll see two columns here. One is with the tax exemption, so essentially under current law. The other is if there was no tax exemption. The difference will illustrate what the cost of the tax exemption is.

So, wages of $50,000 taxable income. Once you figure all the deductions and exemptions, it is $30,000 before accounting for health insurance. Now, let's say the employer pays $10,000 towards health insurance. A typical health insurance policy is $12,000 or $13,000 for a family. Let's say the worker contributes $2,000 towards that health insurance, so for a total premium of $12,000—the $10,000 plus the $2,000.

So, their wages, accounting for the fact that let's say this worker has the section 125 plan, so they get to deduct their $2,000 contribution towards insurance from their wages. Their wages, after accounting for that contribution, are $48,000. So, those are essentially their taxable wages.

Their taxable income, after accounting for that, is therefore $28,000. So, they started out with $30,000 in taxable income and they get to subtract the $2,000 they paid

for health insurance, so taxable income is $28,000. If you work through all the calculation, trust me that you end up with income taxes of $3,398. The worker also pays payroll taxes. Everyone pays payroll taxes for both Social Security and Medicare. Those amount to $3,672. The employer pays and equivalent amount in the same payroll taxes. Those are also at $3,672.

Now, let’s quickly work through what would happen without the tax exemption. There’s the same $50,000 in wage, same taxable income before accounting for insurance, same contribution towards insurance by the employer and the employee. But now if you look at the wages with the insurance, because now the health benefits that the employer provides become taxable, you add the $10,000 in the employer contribution towards insurance to the individual’s wages, so now there are taxable wages of $60,000 with $50,000 plus $10,000. The taxable income similarly goes up by $10,000 and it’s now $40,000 rather than $28,000.

So, of course, the income taxes that this family has to pay go up to $5,198, which is an increase of $1,800 with the tax exemption. And you’ll notice, if you have a calculator in your head, that that $1,800 is 15-percent of the insurance premium. And the reason that that’s the case is because this family is in the 15-percent income tax bracket. And the

payroll taxes that the worker pays and the employers pay also go up.

I won't run through another example, which shows a higher-income family, but just note the bottom line, which is that this is a family that's making $200,000 a year and so they're in a higher tax bracket, the 28-percent tax bracket rather than 15-percent. If you look at what the effect of the exemption is, it's quite a bit higher because it's a higher tax bracket.

Interestingly enough, the payroll taxes are actually a much smaller difference. The reason for that is the Social Security payroll tax is applied only to a wage base, wages up to $102,000. So, since this family is already above that $102,000 it doesn't matter that you're adding the cost of the insurance premium to their wages. They would still pay no more in Social Security taxes. They would just pay a small additional amount due to the Medicare tax, which doesn't account for that wage cap.

Now we're getting to the stuff Ed cared about, the money. If you think about the cost of this tax exemption, there are a few things to keep in mind. The first is that even though it's in the tax system, not in the budget as a program, it really acts very much like an entitlement. The cost goes up every year, typically by about the amount of the increase in health insurance premiums, through no act of Congress, through

no appropriation from Congress. So, it basically acts and smells like an entitlement.

Interestingly enough, the subsidies from the tax that workers receive are in many ways hidden. It's not like a worker receives anything from their employer or from the federal government that says, here's the subsidy you just got for your health insurance; it's really just almost the lack of a tax that produces the subsidy. So, it's not something that I think workers are necessarily particularly aware of or think about. And in many ways it's hidden from the federal budget as well, because it's not really an on-budget expenditure.

Now, that also means that it's also very hard to estimate the cost of the exemption, since it's not a line item, it's not an actual expenditure, it's not a set of checks that the federal government sends out. The only way to assess the cost of the tax exemption is to do it with a statistical model of the health insurance system. It can only be estimated, and estimates are actually quite a bit all over the map.

In presenting an estimate here based on work by Jonathan Gruber that he did for us from MIT, our estimate is that the total federal cost for this tax exemption for employer coverage is about $225 billion a year this year, in 2008 dollars. If anything, that's an underestimate because it applies just to active workers. In fact, coverage that retirees get from their former employers are also tax-free, and

states also have a cost of providing an income tax exemption for states that have state income taxes.

Now, if you think about the examples I presented earlier, it's not too surprising that the cost of the tax exemption varies quite a bit by income. This shows the average tax subsidy, the average cost of the tax exemption per worker by the income of the family. You can see for low-income families, those making under $20,000 a year, the average subsidy per worker is only $319, whereas if you look at families making $150,000 a year or more, the average subsidy is over $2,800.

There are really two reasons for that. One is from the examples. If you're in a higher tax bracket you get a higher subsidy. The other reason is that higher-income workers tend to be much more likely to have employer coverage available to them. Low-income workers do not and therefore do not get a subsidy.

Now, in a minute Bob is going to present some of the options for what might be done with this, but underlying that debate are a number of argument, both for an against this current tax exemption.

Arguments for are that—not surprisingly, since it's only for employer coverage—it encourages employer coverage. For many people, that's an important thing. And importantly, employer coverage is very good at grouping people with very

diverse characteristics, young and old, healthy and sick, so by encouraging employer coverage, the tax exemption encourages the pooling of risk, of diverse people, which does not tend to be done in the non-group insurance market, where people who are sick can be excluded through medial underwriting.

The tax exemption also reflects trade-offs that the workers, particularly those in unions, have made over the years to trade off wage increases for increases or even maintenance of health insurance benefits. Removing or capping the exemption would, in some sense, disrupt those trade-offs in union and employment negotiations.

Now, in terms of arguments against, the first I think is fairly obviously, which is that because it benefits higher-income people more than lower-income people, it's a regressive benefit. A disproportionate amount of the benefits of the subsidy go to higher income people. Also there is no subsidy for those without employer coverage, so in some sense it's not really a level playing field for people who don't have access to employer coverage, those whose employers don't offer it.

Critics also argue that it encourages over insurance. I know, certainly when I go out and speak in the general public, that the idea of over insurance is not a concept that people find particularly intuitive. But the idea of providing the subsidy, essentially putting insurance on sale where the government is covering a portion of the cost of insurance, no

matter how expensive it is, encourages people and encourages employers to offer more insurance, so more generous insurance is provided than would be the case if there were no tax subsidy.

Also, because of the nature of the subsidy, because it's uncapped, because it's not on budget and really acts like an entitlement, there's minimal ability for the federal government to control the cost of the subsidy. Really, the only way to do that is to control the underlying cost of private insurance. If we knew how to do that, I don't think any of us would be here.

Before I turn it over to Bob, who's going to present some options, I just want to illustrate how much money we're talking about here, in the context of a potential health reform debate. If you think about this tax subsidy starting out at about $225 billion this year and growing over time at roughly the increase in health insurance premiums, which CMS estimates will be about 6.2-percent a year, if you total that up over 10 years, it's about $3.4 trillion, which, even in these times, sounds like a reasonably large amount of money.

If you imagine this tax exemption growing not at the increase in health insurance premiums, but let's say at inflation instead, which is under 3-percent—so, you didn't reduce the tax exemption; you just reduced the rate at which it grew—after 10 years the cumulative federal savings would amount

to $580 billion. So, this is not a specific proposal. God forbid—this is not an official CBO score. But it kind of gives you a sense of the amount of money we're talking about, which I think is why people are going to be paying attention to this over the coming months. Thanks.

ED HOWARD, J.D.: Terrific, thank you, Larry. As Larry indicated, we'll now turn to Bob Lyke. Bob has been serving Congress directly as a staff member at the Congressional Research Service of the Library of Congress for nearly 34 years. Lately, we're lucky to say, he's been doing a great deal of work on how tax policy and health policy intersect, with an emphasis on some of the proposals that you've seen in other places change the current tax treatment.

So, we feel exceptionally fortunate to have him on the panel today. Bob holds a Ph.D. from Yale. He's taught at more colleagues than I've attended. I don't want to take offense here, but something about not being a lawyer or a tax accountant—speaking as a lawyer, I want to make sure that you know that Bob is also a CPA, but don't hold it against him. Bob, please come on up.

ROBERT LYKE: Thanks, Ed. My job is to talk about the four tax proposals that are shown on the screen, but we have some challenges here, both for me and for you.

One is that when you mention the phrase "income taxes," immediately a lot of people get anxious. Clearly this is the

case each April 15. But it's also true throughout the year if one is given the responsibility of figuring out what is appropriate income tax policy, particularly for healthcare.

Many of the people in this room might agree with the statement that was made some time ago by a former resident of Princeton, New Jersey, which shows up on the screen there. For those of you on the far left, it's a statement by Albert Einstein saying that the hardest thing to understand in the world is the income tax. Certainly that is true in terms of calculations.

Income tax calculations can be quite challenging, even for tax professionals, and it's particularly true if we start tampering with exclusions and tax deductions because changes there, even small changes, can affect a number of other tax attributes. It's perhaps less true if we're talking about a refundable income tax credit, although they also can become quite complicated.

In any case, the tax complexity, with respect to calculations, I think is something that we can set aside at the present time. There are bigger challenges that we should be aware of.

First of all, with respect to these proposals that show up on the screen—let me go back to them—these are generic proposals. They have many variations. And as a consequence,

what one says about a generic proposal might not actually apply to a particular variation.

On the other hand, if one were to talk about a particular variation, one might be talking about something that is unrepresentative of other variations for that same proposal. So, when we're talking about these things in a generic sense, as I will necessarily have to be doing today—sort of at 60,000 feet, as the metaphor goes—just be aware that if you get a lot closer to the ground on a particular proposal things could be different.

Secondly, details matter. Details matter in a big way. Minor changes in details, with respect to some of these tax provisions, can lead to significant differences in outcomes. One example that I will leave you with at this point is suppose we're talking about a refundable income tax credit for the lower income tax population.

The issue that arises is to whether people who are participating in Medicaid, or are perhaps eligible for Medicaid, should be able to receive this credit. The choice there is whether we're going to exclude people because they're simply eligible for Medicaid, or only if they participate in Medicaid, can lead to significant differences in both the cost of the credit and its functioning and its impact on the health insurance markets.

As I said, we necessarily have to be talking sort of at 30,000 feet here, but if we were to try to evaluate a particular proposal, we would have to drill down and deal with some of the complexity.

To begin with, we would have to identify the objectives that we want to achieve with changes to the tax system. Now, at one level this sounds pretty simple. Many people in this room—perhaps nearly everybody in this room—would say, well, one thing we want to do is to increase coverage to people who don't have insurance. However, people are also likely to say we also want to deal with costs and holding down the growth of expenditures. And then the more you think about it, the more you begin to think, well, there are other things that we want to accomplish as well.

We want to subsidize people who need insurance. We want to keep things simple. We want to give people choices. These are kind of the principle objectives that often arise when people start thinking about these matters. The tricky thing here is that a number of these objectives conflict with one another.

For example, extending coverage to more people will generally conflict with trying to hold down costs. Giving people choices and ordinarily targeting benefits to people that most need them can conflict with simplicity. One of the challenges in either evaluating a tax proposal or, more

importantly, designing a tax proposal, is how one tips—one way or the other—on these varying objectives, how one weighs them against each other.

Secondly, it is also important to determine the likely range of premiums. In fact, if there's any one thing that you should remember from the talk that I'm giving right now, it is that if you're starting to think about changing the tax system and you want to figure out what the impact would be, the place to begin is not with the tax system, but instead to begin with the question of the insurance markets.

Begin with the question of whether or not insurance should be loosely regulated, so insurers can charge whatever they want, or whether it would be tightly regulated so that there would be rate bandings, perhaps community rating. Until one has an answer to that question, it is virtually impossible to do an assessment as to the effectiveness and the impact of a tax provision.

Now, having said all those preliminary things let me move onto the four proposals that I am to talk about. I might mention that these are only four proposals that are kind of currently in play, as it were. There are other tax proposals that are out there that deserve our attention, too—for example, making significant changes to the payroll tax in order to pay for the healthcare reforms and so on and so forth.

But let’s begin with this one, which, as Larry has indicated, is getting perhaps the most attention right now. Some possible gains that would occur if we were to end the tax exclusion for employer-provided coverage include the list of things that I show there, I say possible just because it is actually possible in some instances to have variations of this where this would not be a principle outcome, so you really have to look to the details. But, once again, we’re at 60,000 feet right now.

The first thing to note is that the savings that one would achieve from this, which are somewhere on the order of well over $200 billion, could be used to finance other aspects of healthcare reform. It is my sense that this is one of the principle reasons why this provision is being advocated by some people on the hill, in contrast to an explicit tax increase, which could have much the same mathematical effects.

Exactly how much money would be raised depends on exactly how this exclusion is changed. If one looks into the Internal Revenue Code, it’s Section 106-A if you want to kind of drill down to that level, it doesn’t talk about the exclusion applying to health insurance. It talks about it applying to accident and health plans. Accident and health plans cover a lot more than simply what we would normally consider to be health insurance.

It includes flexible spending accounts, health reimbursement accounts, and premium conversion. It could reach, in some instances, to workplace health improvement programs. It's a fairly complex topic, so if one is to move in this direction, one ought to simply beware of unintended consequences and think very carefully as to how the drafting should be done.

I have a new report on this exclusion that is included in your packet, and there's a discussion on some of the complexities that arise there.

Secondly, ending the exclusion could also end the open-ended subsidy and might hold down the growth of healthcare expenditures. Most economists would agree with that statement. I, myself, agree with it. The interesting issue here is really one of quantification. The best work done by economists on this issue really occurred some time ago, beginning with a seminal paper by Martin Feldstein in 1973 that was then updated.

It was very, very solid, very impressive and very engaging work, but that was done largely before the rise of managed care. It would be interesting to know exactly the extent to which the current health insurance arrangements among employers would lead to significant savings. We don't have a good grasp of that.

And then the other thing that is crystal clear is that if we ended the exclusion this would reduce the tax savings that higher-income families get, as Larry indicated on his slide. Families in the 28-percent tax bracket get a larger tax savings than families in the 15-percent bracket. That is incontrovertible. That would be the impact on that.

Some possible problems that might arise if one were to simply end the exclusion would be that it might undermine employment-based insurance. We don't have a good grasp on this either, because we don't know the extent to which the tax provision in and of itself is propping up employment-based insurance. Certainly it's a factor in it and no one denies that, but there are other reasons that employment-based insurance is attractive.

Larry mentioned the pooling and there is also the fact that it is a convenient way for employees to get insurance. They don't have to go out and shop around; someone's done the shopping for them. And also, from the employer's standpoint, it's an attractive benefit for being able to attract and retain high-quality labor.

So, it's very difficult to know exactly what the impact would be. If I had to surmise anything, I would say that for large employers, ending the exclusion might now have much impact. However, for small employers, yes, a number of small employers could very well end their employment-based plans.

Depending in part upon what we replace this with, typically ending the exclusion is coupled with another tax reform, such as I'm going to talk about very briefly here. One would have to look to that, as to how you design these other tax reforms, such as instituting a generally available deduction or a widely available income tax credit. That could or could not affect the availability of employment-based insurance.

So, it’s possible to come up with kind of a general statement on this, but one just needs to bear in mind that there can be complications here, once again depending on the specifics.

If the insurance were to suddenly become taxable to the worker, the question would arise, well, exactly how much money should we assign each worker? In the example that Larry [Inaudible 00:36:27 to 00:36:41] be given an additional $10,000 worth of taxable income. And indeed, that is the solution that is usually put forth for this problem. But if stop and think about it, we should bear in mind that employment-based insurance is actually worth different things to different people.

Imagine that 25-year-old guy who thinks he’s invincible. Insurance is probably not worth $10,000 a year to him, even if it is paid by the employer. You can contrast him with someone in their early 60s who has a whole series of very

complicated healthcare problems and indeed is in an age band where we all know that risk is a lot higher. Insurance is probably worth a lot more than $10,000 to that person.

Indeed, it was because of this problem that prior to 1954, as the predecessor agency to the Internal Revenue Service was trying to issue rulings as to whether or not employment-based coverage should be taxable, the rulings by and large said, well, for group coverage we're going to make it tax exempt because we can't quite figure out how to tax the individual worker.

Whereas if the employer provided individual coverage—that is, allowed workers to buy individual coverage and then the employer reimbursed the employee—then we know exactly how much we can tax the person because, after all, there is a price for individual market insurance. So, that is just one added complication here.

And then the final point to be made about the tax exemption—I'm also echoing Larry here, who has taken all my good points—is that tax exemption is simple—things are just left out—whereas a replacement tax benefit, particularly a tax credit, could become very complex. To the extent that one wants to keep things simple, this is a factor to take into account.

Moving on to the second proposal, it is to allow a full deduction for healthcare premiums. A possible gain here is

pretty evident. Once again, Larry has given the answer away. It would be a lot more equitable for people who buy insurance in the individual market. Right now, as he correctly stated, most people who buy insurance in the individual market cannot receive a tax benefit for doing so.

Very few people actually qualify for that itemized deduction that allows you to get a deduction to the extent that expenses exceed 7.5-percent of adjusted gross income. So, simply on grounds of tax equity, it is very difficult to think why this should not be enacted.

Indeed, this could be done pretty simply. That is, all people who are purchasing insurance in the individual market would simply be able to subtract the cost of that insurance from their gross income, and it would not have to get into additional complications.

Some possible problems that might arise, however, are that in and of itself this would not do much to increase the number of people who have insurance coverage. We can all understand that with a simple mathematical example. Suppose that the cost of the insurance is $10,000 and one is in the 15-percent tax bracket, as many middle-income families are. Lower middle-income families would be in an even lower tax bracket of 10-percent, but let’s go with the 15-percent example.

A $10,000 deduction for a family in the 15-percent bracket leads to tax savings of $1,500. They would still have

to come up with the other $8,500 in which to purchase the insurance. We know that for many people, particularly at the lower end of the income scale, it is the cost of the insurance that is the principle barrier to them actually obtaining the insurance. One way to describe this is that the uninsured person is down a 50-foot hole and we are throwing him/her a rope that is 10 feet long. It really doesn't do much good if they can't jump up those 40 feet.

The other thing that could be said here is that this might undermine employment-based coverage, I think because of what I just said, which is that this might have minimal impact for people obtaining coverage. By similar analysis, I think that this is likely to have an affect only in the small employer market. I don't think it would have much impact in the large employer market.

One alternative that is sometimes suggested here is to have a fixed standard deduction for health insurance. This was proposed by President Bush in his budget in the previous year and also was included in his budget for this year. This would allow workers and family members to deduct a flat $7,500 if they purchase individual coverage or a flat $15,000 if they purchased group coverage, regardless of the cost of the insurance. That certainly has an attraction of being very simple. It would perhaps limit the purchase of overly generous insurance, which simply allowing a full deduction would not.

On the other hand, it might encourage some people to go ahead and claim this full deduction, but at the same time buy insurance that really is not adequate.

Moving on to the third proposal, a possible tax credit for individuals, nearly all tax credit proposals are for tax credits that are refundable. That is, taxpayers can get them regardless of their income tax liability. If they have no income tax liability, they are still given the full amount of the credit. And it is also what is called advancable. That is, the credit can be advanced directly to an insurance company, so you don't have to wait until you file your return in order to get the money.

Possible gains that would happen here are that you could fine-tune the subsidies according to family income. You could do very precise balancing of the competing costs and coverage objectives. For many, a tax credit would be simpler than asking people to apply for a program subsidy, as we do for Medicaid or SCHIP. In fact, if we attempted to extend that type of application process to the entire population, it is pretty clear that state agencies would be overwhelmed.

And the other virtue here is that a tax credit would be easy to modify, so Congress could kind of give it its best show one year, then watch what happens, and then very easily go in and make some minor modifications.

Possible problems that arise with a tax credit are that a fixed credit amount—let's say a fixed percentage amount of 30 or 40-percent. If everybody were allowed to get a tax credit equal to 40-percent of the cost of the insurance, two problems are immediately available. First of all, this isn't enough to help people at the low end of the income scale actually obtain the insurance, because they still have to pay for the rest of the insurance.

And secondly, it might overly subsidize people at the high end of the income scale. At a certain point, if someone is earning over a million dollars, we might say they could really afford insurance by themselves and we shouldn't give them a subsidy, let alone a subsidy equal to 40-percent of the cost of the insurance.

So, that then leads to the most common variation here, which is that we should have what's called an income phase out for the credit, so that you might allow a full credit for folks up to, let's say, about 100-percent of poverty and then we gradually reduce the credit to zero at maybe 400-percent of poverty or 500-percent of poverty or something like that.

This is challenging. It's challenging to know exactly where you should start that reduction and it's challenging to know exactly where you should end the reduction, moreover, if you're basing the reduction on family income, the income measure that is best suited for this comes from the second

prior year. Need to just take a second and explain that if I may.

Here we are at the end of 2008, people are applying for insurance in 2009, but at this point in 2008, people have a good measure only of their 2007 income, they don't know for sure what their 2008 income is and they certainly don't know what their 2009 income is.

And so there's a possible disconnect between the timing period for the measurement of income and the year in which the insurance is delivered.

Let me move on to the final topic here, which is the employer tax credit. The usual proposal here is it is for small businesses, particularly with a low wage workers. One of the important gains here is that you could really get a lot of bang for your buck because you could focus the tax subsidy at a part of our labor force that we know often has difficulty obtaining insurance.

One of the problems that arises with this is that often low wage workers are not low income families. Employers do not know the income of their workers, they know what they pay them in wages, but they don't know their income. This is particularly true if the worker has a spouse, but even so, the worker might have another job that he or she does not want to indicate to the employer.

Some concluding points. Tax provisions are tools, one should tool only after one has decided the objectives, it really can't work the other way around. You can't even evaluate a tax proposal unless you have a good idea as to the standards by which you're going to evaluate it.

Secondly, new tax benefits involve costs. Somebody's going to be paying for this. Sometimes that payment will come out of just general taxes, but I've also been in situations where people were envisioning one way to pay for middle class tax break is to reduce the expenditures for Medicaid. So you get into those types of issues within the health care system by itself.

And finally, one should always be thinking of alternatives, particularly expanding public programs. There's some things that the tax system just can't do very well for some people. Imagine, if you will, a homeless person. It's kind of hard to think of exactly how a homeless person could benefit in any effective way from an individual tax credit. The administrative burdens would be just too great.

And then secondly, expanding the amount that people have to pay out-of-pocket, we aren't going to run all tax expenditures through the health insurance system, let alone the tax supported healthcare system. So, it becomes very important then to think of ways that people can effectively be made to pay more for their own expenditures.

Just one final comment here; here is a quotation from a former president. I'm not going to identify him. I will indicate that I had to clean up the language a bit for this public presentation. For those of you off on the left it says, "I can't make a thing of this tax problem. I listen to one side and they seem right, then I talk to the other side and they seem just as right and here I am, where I started. What a job I have."

And so for those of you who have to deal with this, what a job you have.

ED HOWARD, J.D.: All right. Great. Thank you Bob. All right, now it's time for you to do your job, which is to fill in the blanks because as much information as you have just received, the Internal Revenue Code holds many more mysteries that you have yet to explore. And I would offer you the opportunity to come to one of the microphones at the front.

I apologize for the lack of elbow room to get to them. And also, if you take the time to put a question on one of those green cards and hold it up, someone will try to squeeze down your isle and pick it up from you. Alright, and if you would identify yourself and direct your question, if you need to, sir.

JOHN GREENE: Sure. John Greene with the National Association of Health Underwriters. I appreciate your comment about markets, because the market in New Jersey is vastly

different than the market in Virginia. There's also income differences around the country, they have a higher cost of living in New Jersey, they make higher incomes, you might pay $5,000 for a product and that very same product in Virginia is $500.

So if you're a well-off person in Virginia and you are trying to do this balancing act on providing adjusting this subsidy correctly, you're going to still advantage the person in Virginia over the person in New Jersey and I don't know how you fix that when you have markets that are vastly different in terms of wage differences and regions of the country as well as the cost in the premium that you mentioned was so important.

ED HOWARD, J.D.: And the question is?

ROBERT LYKE: Well, let me just say you're absolutely correct. Actually I did have a slide that I took out that got into those issues. To some extent, these variations apply right now with the exclusion, that is the exclusion is giving greater subsidies to people that live in one part of the country rather than another part of the country.

But if one were to try to come up with a generally available individual income tax credit, all of this would have to be made explicit and articulate and congress would have to wrestle with what is the appropriate credit for people in those different sets of circumstances that were just identified.

Now I'm not denying that congress has the capability of doing this, congress does this in a lot of other instances, but it does raise the visibility of a very difficult apportionment issue. And there's no simple outcome to this. People are going to disagree as to what is the appropriate level in one place versus another, just as people disagree all the time about the appropriate level of appropriations for various state program grants.

ED HOWARD, J.D.: Yes, I once heard a treasury official who was wrestling with the trade adjustment tax credit describe what he thought was the ideal system, which was an age adjusted, income adjusted, geographic adjusted, health status adjusted tax credit. And he said, but of course we couldn't have administered that. Yes, go ahead.

GENE GERM: Yes, Gene Germ [misspelled?] from the Heritage Foundation. Thank you for your presentations. Could you discuss what role the employer tax exclusion plays in fostering job lock?

LARRY LEVITT: Sure, I'll take it. I mean, the key is, which I think both Bob and I said, the tax system now primarily subsidizes employer based insurance and not individually purchased insurance and there's certainly some job lock inherent in that and that people can't take an employer plan with them from job to job, particularly another job that

doesn't offer health coverage. So that, I think is the level playing field.

There's both an equity argument, I think as you suggest, for providing subsidies for people who buy coverage on their own, but also potentially a kind of making the labor market work a little smoother.

I would say, and I think Bob and I both implied this, kind of changing the terms, and so right now we provide subsidies for employer based coverage, not non-group coverage, if we started to provide subsidies for non-group coverage, let's say a deduction, a tax credit, that would also change the nature of the choice employers make, that employers might be more likely to drop coverage so people would shift from employment coverage to non-group coverage and some individuals might decide that they would now switch out of an employer based plan.

[Inaudible] to a pretty substantial movement of people away from employer based plans into non-group plans, which some people is a good thing and some people think is a bad thing.

BOB: Larry, is there any good research that tries to quantify this job lock phenomenon?

LARRY LEVITT: Not that I'm aware of. I mean, we've done some polling, which I don't have the numbers off the top of my head about the number of people who say they've stayed in a job because they couldn't get insurance elsewhere. But it's

at least based on what people say, it's not an insignificant phenomenon.

ED HOWARD, J.D.: Yes, Bob?

ROBERT LYKE: One other comment --

ED HOWARD, J.D.: I'm sorry. Two Bob's here. You're on the panel.

ROBERT LYKE: The one other comment that I would make is that job lock it sounds like such a negative thing, indeed, as we normally think of it, it is, that is people are being held to a job where they really would prefer to be elsewhere and their skills would be better utilized elsewhere.

But from some perspectives, some degree of job lock is actually a good thing. For example, we know that employers are more willing to provide training to workers if they think that workers are going to stay around awhile. And if people could get up and go at any particular time, employers are less likely to offer training.

To the extent that we need to factor this into our considerations, I think that the whole issue becomes much more complicated than is usually presented.

ED HOWARD, J.D.: Yes, go ahead Bob.

BOB HELMS: Okay, Bob Helms with AEI. I first would like to plug a book, but it's not an AEI book, it's a Brooking's Institution book. They have a new book out on the tax treatment of health insurance edited by Henry Aaron and Ben

Burman and so there's lots of good detailed discussions of these issues in there. I also have a chapter in the book. [Laughter].

Just a couple of things. Larry had mentioned that you use the Jonathan Gruber estimates, there are several estimates out of this. I'll mention John Shields from Lewin who estimates that this has like 225 billion; I think he's up around 300 billion, but he includes the effective state income taxes also in that.

But also, using John's figures since 2000, just you're talking about this as a hidden subsidy; it's been going up at about 16 billion a year of lost revenue. And so if you look at it that way and imagine if that were in part of a debate on the Hill about explicit expenditures, you'd think somebody would pay attention to it, but it is hidden here.

One other thing I comment on Bob's presentation, he kind of skipped over the alternative to eliminating the exclusion, just a simple tax calc, which we proposed in the Reagan Administration. But we didn't get into the whole issue of trying to decide what was an excessive policy as your slide implies.

We just put it at like 85-percent of the meeting, as I remember and just let the market define what's excessive. The point was that all the people who were above it would have very strong incentives to get on to the calc.

ROBERT LYKE: If I could just comment on it, I mean I agree with everything you said Bob and that perspective certainly should be given very, very serious consideration if one is thinking about a cap.

One of the issues that's been raised, however, is that let's say the cost of your insurance is above the 85-percent level, one has to look very carefully as to exactly why that is the case. It might be that you're caught in a small group, perhaps working with a small firm where many of the workers are on the older side rather than on the younger side. Or there might be a family member that has some very serious health care condition that's driving up costs.

And as to whether or not we should still put pressures on them to restrict the cost of the insurance, I think that's a public policy issue that congress just needs to face squarely and make a decision about.

It might be possible to figure out some technical variation whereby one can get to the same place that Bob is suggesting and that would be some very interesting work that needs to be done.

ED HOWARD, J.D.: Sort of following up on that and some of the other implications of the discussion so far Bob, part of the discussion that one often hears when income tax changes are discussed have to do with doing something about insurance

regulation at the same time. Let me just say, community rating, for purposes of an example.

If you had a community rated system, then establishing the amount of a credit or a deduction would pose a lot fewer difficulties from a policy standpoint, is that fair reading?

ROBERT LYKE: That's correct. Yes.

LARRY LEVITT: Ed, I would just add that, that's certainly true and I think as Bob emphasized, that you can't just talk about the tax system here, you have to also talk about the health insurance system. But even if you made those kind of regulatory changes to the individual market or the non-group market where people buy on their own, still among larger employers, they're largely self insured or experience rated, so you still have the issues of cost varying by geographic area, by the nature of the group, you know, a manufacturing firm with quite a number of older, sicker workers faces a higher cost than an accounting firm, let's say, with younger healthier workers.

ED HOWARD, J.D.: I've got several questions that have come forward on cards. Most of the proposals, the question writes, that have been discussed here and during the campaign, imply that buying coverage on the individual market is no different than group coverage costs. But it is. Wouldn't this just further increase spending for coverage? This, presumably being the kinds of changes that Bob was describing.

LARRY LEVITT: There are a number of ways in which the individual and non-group market varies from the group market. One is administrative costs and those are definitely higher in the non-group market than in the group market. Those are primarily marketing costs that are much cheaper when you're marketing to a big group than when you're marketing one by one to individuals. So in that sense the non-group market is more expensive.

The current non-group market, because it's medically underwritten, meaning that in most states, in a vast majority of states, people with pre-existing health conditions can be excluded or charged higher premiums. Actually, the average cost of people in the non-group market is less than in the group market because it's a much healthier than average population. So when you go on ehealthinsurance.com and you look at the health insurance premium, part of the reason that premium is low is because it's a healthier than average population.

ED HOWARD, J.D. Very good. A questioner asks the panelists to discuss the pros and cons of requiring employers to just disclose the cost of employer-provided health insurance to their workers, kind of a W-H, if you will. Is that a good idea? There are some pieces of legislation, I think, that would do that. And there are some companies that do it voluntarily.

ROBERT LYKE: Yes, there are some companies that do it voluntarily. No one can oppose disclosure. I mean disclosing

things are good. It’s very appropriate that workers begin to understand exactly how large their employer subsidies are. The tricky thing, however, is getting back to that issue I mentioned earlier, which is that the actual value of the coverage is going to vary by worker. And so the average could be misleading for not just some, but indeed for many workers.

Also, there’s another aspect of this that needs some further research. Mark Pauly up at the University of Pennsylvania some of this. Louise Sheiner did a paper for one of the Federal Reserve banks, now about 15 years ago. It relates to the question of when employers pay for coverage for their workers, to what extent are the workers cross-subsidizing each other in ways that aren’t apparent.

One of the arguments that’s been put forth by both Louise and also Mark and that mirrors arguments that have long been made in the pension system, is that older workers cross-subsidize the cost of younger workers because older workers find that insurance, or pensions if you will, are more important. As a consequence, older workers are willing to give up some of their wages to, in effect, bribe younger workers to participate in the system.

Obviously, this is a very difficult thing to tease out. Mark and Louise have both done some, as I indicated, some interesting work. But it’s simply an indication of the

complications that are involved in what would appear to be a simple act of disclosure.

ED HOWARD, J.D.: That's very interest. Yes, would you go ahead please.

JENNIFER FRIEDMAN: Jennifer Friedman, Ways and Means Majority Staff. I apologize, I was a few minutes late so I missed the beginning of the first presentation. I haven't heard, since I've been here, any discussion of how many people we're talking about with regard to the employer exclusion.

So I think it's important to remember that one of the handouts said 60-percent. It's 160 to 170 million people. There's a lot of people we're talking about that get their health care through their employers. I think one of the lessons we all can recall from '93, '94, is that people are really afraid of change. We only need to recall the Harry and Louise campaign to know that.

So the point and question I'd like to make is, how do you reconcile that political lesson of people fear change, with this concept of potentially, and I know once I said "may undermine", but of undermining the healthcare for 160 to 170 million Americans. I think there's many folks who would fear that blowing up the employer exclusion means you're blowing up healthcare reform. So I just sort of wanted to put that point out there and get a reaction.

ED HOWARD, J.D.: Let me give you one more piece of context for the point that Jennifer makes. Somebody sent up a question along these lines. As the panel knows, the policy of changing the employee exclusion was vilified in the presidential election. Do you believe that such a policy can be pursued next year, or are any changes to the employee exclusion now off the table? So it's the political version of your very personal representation.

LARRY LEVITT: Well, thanks Ed, you just made a hard question harder. I have a couple of observations. One is, the numbers you cited are certainly exactly right. And you get a sense of that from the $225 billion that goes into the subsidy. The flip side of that is, I mean it's a lot of federal spending, but it's a lot of benefit that people are receiving as well. I have bruises from the '93, '94 discussion as well.

A couple of observations. One is that any time you change this kind of equation between employer coverage and non-group coverage, you'll get movement away from employer coverage and into individual coverage. Or even if you expand a public program, like Medicaid and SCHIP, you'll get some of that as well. And that's true of the kind of plan that President-Elect Obama has proposed and other Democratic candidates, as well as the plan that Senator McCain proposed.

I think one important thing to keep in mind is what you're providing to people when they move out of employer

coverage. So what's there for them outside of the employer coverage. I think that's an important consideration in evaluating these kinds of proposals.

You know, is it an unregulated non-group market where people can't get coverage if they have a pre-existing condition or have to pay more for it. Or is something like a health insurance exchange like President-Elect Obama has proposed, where anyone could get coverage, regardless of their health status. I also think even if people don't lose employer-based coverage, so even if it's someone who's let's say starting to pay taxes, it's kind of the flip side of the hidden nature of the current subsidy.

As soon as you do even something as minimal as disclosure, or you actually try to tax people on their health benefits, you're essentially taking a subsidy that people didn't even know they had, and now taking some of that away from them. And that's likely not to feel so good.

ED HOWARD, J.D.: But of course, we're not making any political judgments up here, this is a primer. Yes, Howard?

HOWARD SHAPIRO: Howard Shapiro, Alliance of Community Health Plans. You talked about capping the amount of the exclusion. Is an alternative to cap the exclusion for higher income people? Much as the level of what we can deduct from income taxes is capped for higher income people. Could you do

that, especially given the regressive nature of the exclusion. What are the pros and cons of that approach?

ROBERT LYKE: There is certainly a technical issue here which is that the employer does not know the income of the worker. This is something I mentioned earlier. So that if we wanted to ratchet down the exclusion for “high income” families, high income workers, we would have to figure out a way in which to carry that out. It might be possible to do so, but it could be fairly complicated.

Employers themselves would not want to be put in the situation of obtaining income information from their workers and workers themselves would not want to share that information with their employers. One need to simply have more thought as to whether that technical hurdle can be overcome.

Beyond that, there is perhaps a fair amount to be said for making that change. If one has the perception that high income workers are being overly subsidized because of this provision and that we need to, if not eliminate it, at least ratchet it down. Simply on the grounds of equity.

LARRY LEVITT: If I could just add, I don’t know if we want to do policy development on the fly here. But one approach to that might be pairing the sort of disclosure idea with the introduction of a health benefits tax on higher income people. So for example, you could theoretically require all employers

to disclose the amount of the health insurance benefits they provide with all the complications that Bob described.

And then individuals take that amount that's now been disclosed, and if you're a higher income person you're required to put it on your tax return. So the employer wouldn't necessarily have to know your income. But everyone would have to know the value of their health insurance benefits.

GEORGE GREENBERG: George Weinberg, HHS. Bob, I just wanted to go back to one point on your last slide about this stuff gets so complex maybe we should think of other alternatives first, one of which was public programs. Without commenting on the merits, it just seems to me as I'm reading the newspapers, it seems to me the things I've seen and the Bachus plan and some of the other discussions that seem most likely for some immediate action, or not necessarily changes to the Tax Code, but more an SCHIP expansion that sort of extends last year's discussion and possibly a Medicare buy-in as a transition, at least on the Bachus plan to some kind of connector system modeled on a Massachusetts model, which has its own then questions of design and construction.

I'm just wondering if that's what where the political system seems to be going, or does go, whether then that changes kind of all these other factors that you're talking about, that give you some more concrete markers for measuring the effects of the tax changes. And since the world is generally

incremental and it doesn't seem like we're going to get this all done in one bill, if that's the way it goes, then how do you see it playing out?

ROBERT LYKE: Without commenting on either the politics or the way in which things are likely to happen, I simply would indicate that yes, those alternatives, and indeed the alternative that I also mentioned of somehow increasing personal expenditures related to healthcare in a way in which there is no tax preference, that these things really need to be taken into account in order to come up with a coherent change in the tax system. It's simply a lot easier to do that, to mark off the boundaries, if you will, and then figure out how a good tax benefit can be designed within the boundaries.

If we try to include everybody, particularly some of those troublesome populations that you just mentioned, that imposes burdens on the design of the tax benefits that I think are extremely difficult to overcome.

BRETT SWEARINGEN: Brett Swearingen, I'm with Congressman Mark Souder. Definitely not an expert as much as you guys are. The thought I have, is I've looked through this over the past year or so, has anybody ever looked at the sort of hybrid approach between the two sides.

I'm thinking of something like combining a refundable credit with community rating and a mandate, as well as like a health exchange. So that there is no coverage problem.

Everybody's auto-enrolled in some plan. I mean it might be a small plan comparatively. I haven't seen anything like that discussed. I know it's not what Bachus is looking at. I'm just wondering if you guys have seen any other people out there considering such an idea.

LARRY LEVITT: Well, one thing about health policy is virtually every variant has been discussed, so that's you know, it's full employment or it makes our job easier, or what. In many ways that's very similar to what Massachusetts did. Massachusetts has a requirement that everyone provide coverage, a connector as they call it there, or exchange.

A modified community rating, so there's still variations in premiums by age, but no variations by health status. As part of that hybrid what Massachusetts did, was also expanded public programs, as Bob was referencing for lower income populations. Well a state, it's very hard to provide a tax benefit like we do federally.

Massachusetts required employers to make available a Section 125 Plan to workers, which in effect allows workers to pay premiums if the employer doesn't offer coverage, on a pre-tax basis. So essentially it provides the same benefits as a tax deduction would. So I think a lot of the elements you mentioned are what Massachusetts is now implementing.

ED HOWARD, J.D.: By the way, just in passing, requiring the Section 125 accounts in effect taps a federal

source of revenue for the support of the system in Massachusetts.

A question I think the first part of is directed to you, Larry, asking if what you said was that HSA dollars can be used only for preventive services.

LARRY LEVITT: No. If I did say that I certainly didn't mean to say that. HSA dollars can be used for a whole broad range of out-of-pocket healthcare expenses. The issue with preventive services is that in order to quality for an HSA to have a Health Savings Account, you have to have a high deductible health insurance plan.

The only thing that can be exempt from the deductible are preventive services. So health insurance policy can provide preventive services irrespective of the deductible, but can provide no other kinds of services, like say, prescription drugs exempt from the deductible.

ED HOWARD, J.D.: Why can't FSAs be rolled over? And would it generate a CBO score?

LARRY LEVITT: I think it would probably would generate a CBO score. Your question might answer your question.

ED HOWARD, J.D.: We have a few more questions on cards. Let me just ask you as we continue here that if you do have to leave, please fill out that blue Evaluation Form to help us make these programs even better in the future for you.

If legislation retained employers ability to write-off their, that is to say deduct, their contribution from their own business income, but eliminated the exclusion from workers' income, do you think that would substantially change employer-sponsored enrollment? The comment accompanying that the chief beneficiaries of the current expansion are higher income and I don't see the exclusion affecting their desire for ESI. So, answer the question, quibble with the observation, or some combination of the two.

LARRY LEVITT: I'll start. This is, frankly, one of the hardest things, the things I have the most difficulty explaining, or trying to explain to anyone, and maybe I'm not so successful at it. The exclusion, so the idea that essentially employees are getting a benefit from the tax subsidy for employer-based coverage. It seems not to make a lot of sense that if you got rid of that why would fewer employers offer coverage.

The reason comes from economic textbooks which you can choose to believe or not. But the idea is that when an employer is hiring a worker, they're providing compensation to that worker. That compensation might include wages; it might include benefits, like health insurance.

When you start taxing that benefit it makes the workers for that employer not value health insurance in quite the same way that they do now. Therefore employers would have less of an

inducement to offer that benefit in order to attract workers. So I would say virtually any economist you ask would say that even keeping the employer deduction in place, but eliminating the employee exclusion, would result in fewer employers offering coverage.

ROBERT LYKE: I'd like to make one comment, if I could. We've all been talking about the fact that higher income workers get larger tax savings from the exclusion, as indeed they would from a deduction as well. Mathematically you cannot argue against that. It really happens in virtually all circumstances.

In the new report that I did on the tax exclusion, that's included in your packet, towards the end of the report there is a different perspective presented on that, and this is a perspective that would have been much more commonly recognized 20 or 30 years ago among tax professionals. The argument goes this way.

That the greater tax savings that flow to higher income tax payers is a consequence simply of the progressive rights in our tax system, that is, after all, if everybody were charged the exact same tax rate, 20-percent or whatever, then everybody would get 20-percent in savings.

It's only because we have tax rates that start at 10-percent at the low end of the income scale and go up to 35-percent at the high income scale that you get what appears to

be this disparity that is unfair. But then one has to really kind of look at the nature of healthcare expenditures and by and large, not entirely clearly, but by and large the bulk of healthcare expenditures are for what some tax theorists would consider a loss.

That is, they're related to something that the individual would prefer not to have happened, having an accident or obtaining some disease or something like that. And under a kind of conceptually pure income tax system losses ought to be written off at the same rates that income is taxed at.

So by that perspective the fact that higher income tax payers are getting these greater write-offs indeed is not unfair but indeed the opposite would be true if we then somehow limited that. In typical CRS fashion, I do not come down on one side or the other of this argument. I simply present it because I do think that with respect to eliminating the tax exclusion which has been in the Code for over 50 years, it would be a momentous change. Congress can very well do what it wants and Congress will do what it wants on this issue, but it ought to recognize the complexity involved in some of these questions.

ED HOWARD, J.D.: To underscore that point, a questioner just sent up another observation that points out that higher income workers are in a higher tax bracket. They also pay a larger share of the taxes. Same point.

LARRY LEVITT: Not to make an arcane topic even more arcane, but interestingly enough, that we've talked about how you have to consider how the health insurance market works in order to think about these tax changes. Changes in tax rates which is implied by I think Bob's statement, also in effect change the subsidy for health insurance. So if you increase the tax brackets so you apply a higher tax rate to people, you in effect actually increase the federal subsidy for health insurance. Conversely, if you lower taxes, you're actually decreasing the federal subsidy for health insurance.

ED HOWARD, J.D.: And one of the things we haven't really touched on explicitly I don't believe, is the extent to which any of these changes would trigger behavioral responses that are going to reshape the system in ways that we might not have anticipated. Further question?

ROBERT LYKE: Actually, if I could just follow-up on that. If Congress undertakes comprehensive healthcare reform in really a significant scope, one should very well bear in mind that it becomes very difficult to know exactly how far one can estimate what those behavioral changes are.

The Congressional Budget Office document, when it analyzed the Clinton healthcare proposal, this was released in I believe it was early 1994, it might have been late 1993, admitted right upfront that for changes of this magnitude we can only make a general surmise as to what the effects would

actually be. Now they were under a responsibility to come up with a precise number because that's their job, fair enough, but they just kind of issued a warning that these changes could in fact be quite significant.

If I could just squeeze in one other last word here. Good tax policy is not necessarily good healthcare policy, and vice versa because the two systems have different objectives. There are different standards behind them. One should not think that the Tax Code is simply a playpen in which one can move around things at will in order to get all the toys in one corner that one wants to have in that corner.

One can go ahead and do that, but just bear in mind that this might then begin to undermine what originally was thought to be the need for integrity and a fair-based income tax. Or if we wanted to think about a fair-based consumption tax, the same issues would arise.

ED HOWARD, J.D.: A properly profound thought on which to end this program, I think. I want to thank The Kaiser Family Foundation for enticing us into putting this program together and for providing half of what I believe was a very distinguished team of analysts to help us think through this.

Thank you for giving your time to stay with this issue. You may have to make use of this information over the course of the next few months. Join me, if you will, in thanking our panel for a useful and enlightening discussion.

If you haven’t filled out an evaluation form, I’d appreciate it if you would.

[END RECORDING]