2008 Federalist Society Tax Policy Conference Panel: "How our Tax Laws Affect how Health is Paid for and Delivered"

Eileen J. O'Connor, Amy Monahan, Robert B. Helms & Michael F. Cannon

MS. O'CONNOR: Good morning everyone. I'm Eileen J. O'Connor. I'm a partner at Pillsbury Winthrop Shaw Pittman LLP, and it is my pleasure to welcome you this morning to the Federalist Society's tax policy conference, entitled "Our Nation's Founding Principles and Our Tax Code: Consistent or in Conflict?"

I will admit, those are actually my words, and the content of the conference is pretty much inspired by my experience over the past 30 years, as I have engaged in tax practice and have watched clients struggle with the Internal Revenue Code and how to comply with it, as they see other people try to figure out how to get out from under it, all the while weighing what the Internal Revenue Code really does against what, ideally, an Internal Revenue Code ought to do.

The 16th Amendment to the Constitution, ratified in 1913, says: "The Congress shall have the power to lay and collect taxes on incomes from whatever source derived, without apportionment among the several states, and without regard to any census or enumeration." That's pretty much all it says. But you don't have to be paying particularly close attention to the tax laws to appreciate that the Internal Revenue Code has become the repository not only of the rules for what revenues must be paid into the federal treasury, but also for many other rules, and we're going to talk about a few of those today.

Rather than coming right out and outlawing a behavior, lawmakers can provide a disincentive in the tax code. Similarly, rather than coming right out and providing a subsidy for a behavior, lawmakers can, and do, provide an incentive for it in the tax code.

Our first panel is about healthcare—how our tax laws affect how health care in our country is paid for and delivered. Our moderator is Professor Amy Monahan at the University of Missouri Law School, and she will introduce to you her panelists, Michael Cannon of the Cato Institute and Robert Helms of the American Enterprise Institute. Mark Pauly couldn't be with us today because of a death in the family, but he has some very valuable scholarship on his website, as he is a professor. So I encourage you, if this area interests you, to go there and read some of what he has written.

Our second panel today is about charity—whether and, if so, how our tax laws affect charitable activities, religious institutions, and free speech. Our moderator for that panel is Matthew Vadum, and our panelists will be Lee Goodman, Kevin Hasson and Anne Neil.

Our third and final panel is about tax expenditures. We will attempt to define that term, and discuss the wisdom and efficacy of using the Internal Revenue Code to implement social policy. I'll moderate that panel, and our panelists will be Lily Batchelder of the New York University School of Law, Leonard Berman of the Urban Institute, and Stephen Entin of the Institute for Research on the Economics of Taxation.

Author notes appear in text. This event took place on May 7, 2008.

[Video/audio recordings of the other panels can be found in our Multimedia Archive online at www.fed-soc.org.]

Without further ado, then, let us turn to our first panel. Our moderator is Amy Monahan, who is an Associate Professor of Law at the University of Missouri-Columbia School of Law. Ms. Monahan joined that faculty in 2004. Before she joined the faculty there, she had taught at Notre Dame and had also practiced law with Sidley Austin LLP in Chicago.

PROF. MONAHAN: First of all, thank you Lee and the Federalist Society for organizing this conference and having me here today. I'm really pleased that there's a panel at this conference on how the tax code affects health care, financing, and delivery. It's a fundamental issue, and I think one that all too often does not receive enough attention.

Before I turn things over to our two panelists, I'm going to give some brief introductory remarks. The topic of our panel today is how tax laws affect how health care is paid for and delivered. As many of you probably know, the answer is: they affect it fundamentally. The way we finance and deliver healthcare is really tax-code-driven, at least with respect to non-elderly Americans. I'm not going to go into the history of how we got where we are because Bob is going to cover that, but the regulatory system that we have in place now is one that few, if any, would defend in terms of regulatory theory. That said, it does have some benefits, which I'll talk about in a moment.

First: a brief summary of where we are today, for those that might not be engaged with the taxation of employer-provided health insurance.

There is a very significant tax preference given to employer-provided health insurance. Employers can deduct the cost of providing health insurance to their employees, just as they can deduct any other reasonable compensation expense. There's nothing special about that. But unlike other compensation that employers pay to employees, the amount an employer spends on employee health care is excluded from the employee's income for both federal income and payroll tax purposes. So, getting health care benefits from your employer is a much more advantageous arrangement than getting cash wages—because cash wages, of course, are taxed. As a result, employers are encouraged to contribute to the cost of health care they provide for employees: not just to set up a group plan but actually to contribute to it, instead of paying their employees cash wages.

There are other tax benefits as well. For example, the benefits paid from an employer-provided plan are excluded from the employee's income when paid. So, if they reimburse your hospital bill, that's not included in the employee's income. Employers can also set up a cafeteria plan under § 125 of the tax code to allow employees to pay their share of premiums for employer-provided health insurance on a pre-tax basis. As a result, both employer and employee contributions to health insurance can be excluded from an employee's income.

Through a cafeteria plan, you can also set up a healthcare flexible spending account that allows you to pay out-of-pocket health care expenses on a pre-tax basis. Now, those are subject to various restrictions, the biggest one being the "use it or lose it" rule. You have to pre-commit to an amount that you set aside in your flexible spending account, and you either spend it on medical care or your employer gets that money back.

So, things are pretty good for employees that receive health care from their employer. Basically, everything can be tax-free. That stands in stark contrast to individuals who either do not receive health care through their employers or who are not employed. If you purchase health insurance outside of the employment context, you cannot deduct its cost unless you're self-employed. If you're self-employed, you can deduct 100% of the premiums.

Individuals can now also set up health savings accounts, which allow limited deductions for contributions to health savings accounts. Michael is going to speak in greater detail about health savings accounts, how they work, and how they might be reformed, but a health savings account requires, among other things, that an individual set up a high-deductible health plan and be covered only by that plan. However, the premiums associated with that plan cannot be paid on a pre-tax basis unless your employer is offering it, or unless you are self-employed. And finally, individuals can deduct their out-of-pocket medical expenses only to the extent they exceed 7.5% of the individual's adjusted gross income for the year. So there are significantly limited deductions for out-of-pocket health care expenses.

The bottom line is that anyone who has access to employer-provided health coverage usually elects that coverage if they want health insurance, because the tax code skews the economics of that decision in favor of employer-provided coverage. As a result, the majority of non-elderly Americans receive their health insurance through an employer. Additionally, because employer-provided coverage is subsidized by the federal government through tax provisions, we generally think that individuals end up with more health insurance than they would have, absent the federal tax preference. Because of the preference for employer-provided coverage over cash wages, employers offer more generous plans, and employees elect more generous plans, than they would absent the federal tax preference of those benefits.

Two big advantages of this system are based on the group purchasing model. First, group purchasing enjoys lower administrative costs. There's much lower overhead associated with purchasing health insurance as a group than in purchasing it as an individual, and this helps to control costs. The second significant advantage is the risk pooling function of employer groups. Employers are natural risk pooling groups for the most part, and that helps high-risk individuals afford coverage they otherwise would not be able to afford. There's a nice, kind of natural risk pooling there.

The third big advantage, and the one I will leave off with, is that it's easy for employees. One concern with insurance purchase on the individual market is that are tough decisions to make. If you're an individual looking at insurance policies, you have to evaluate a very wide range of factors and make decisions based on future, uncertain medical events. It's a difficult decision. The employer market is easy. It might not actually match your preferences, but it is easy. It's not cognitively taxing to choose an insurance plan from among the ones your employer offers. It's a nice, limited decision process, and we know from behavioral economics that can be a benefit, too.

But the list of disadvantages is longer, and that's probably why we're talking about this today. The disadvantages I would put into two main categories. There are both economic disadvantages and fairness issues. On the economic side, there are huge costs associated with the tax preference for employer-provided insurance. I think one of the handouts you received here today lists tax expenditures. You'll notice employer-provided health insurance is number one on that list. It is the most expensive tax preference item we have in the budget (which is why I think it's so important we're talking about that today). One thing to note is the handout you have refers only to federal income tax issues. We also lose money in the payroll tax system, because those benefits are exempt from payroll taxes. So it's a very big expenditure, a very big cost to us.

The other big economic disadvantage is that this tax preference encourages overspending in healthcare. There are incentives to elect generous insurance coverage. When people have generous insurance coverage, the rational thing to do is consume medical care. You paid for it through your premiums. Your plan is likely to have low cost sharing, so you have a small marginal cost when you decide to go to the doctor. A classic example is when you think you might have the flu. When deciding whether or not to go to the doctor—who you know probably can't help you—you are weighing a decision based on maybe a $20 co-pay. It could be as low as zero. In that case, you might as well go to the doctor—whereas, if you were evaluating that decision based on full cost of service, you might forgo it altogether. So, at least with respect to what I call discretionary medical services, the tax preference leads to over-consumption of medical care, and that's not good for anyone.

On the fairness side, there are several different issues. It's an exclusion from income, so obviously that's going to benefit those in the highest tax bracket. On the other hand, people with little or no income tax liability receive no benefit from the exclusion. And when we think about who we're trying to help or to subsidize—whose behavior we're trying to nudge if you will—it's hard to defend the exclusion on those grounds.

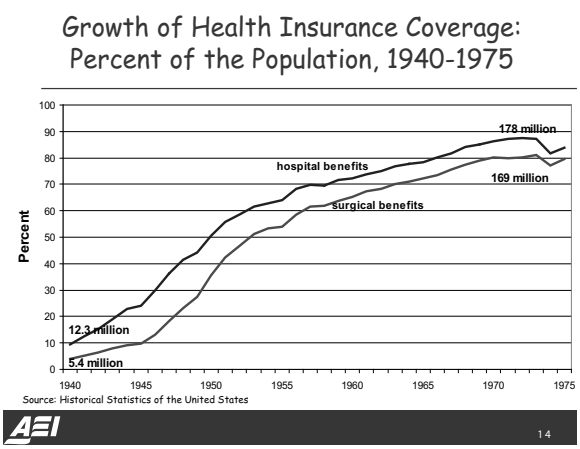
The last issue I want to mention is the disparate treatment. It's very hard to come up with an argument as to why people with the luck of working for an employer that offers health insurance should be able to purchase it on a pre-tax basis, but not those without such luck. This is the basis of an additional, and significant, fairness critique.

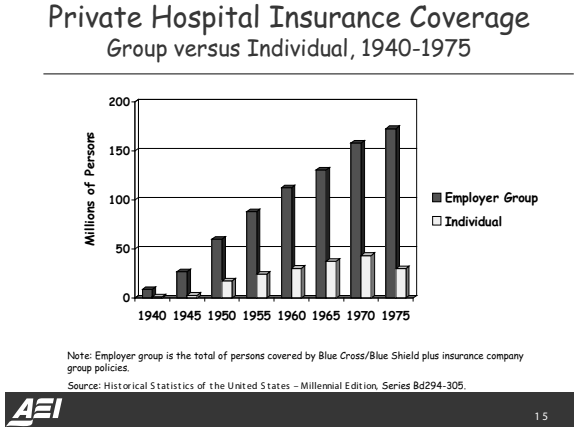
The list of disadvantages is significantly longer than the advantages. That isn't to say they necessarily outweigh them, but the result is that there's a great deal of interest in reforming how we tax health insurance. The big question, of course, is which path of reform one should take. Some people argue for leveling up—meaning, extending the favorable tax treatment to everyone, not limited to the employer context. Others argue for leveling down. Take away the preference from employer-provided insurance and put everyone on a level playing field.

Other proposals, (I would argue most proposals), lie somewhere in-between, and I think that's what we're going to see today.

There are no easy solutions here. First of all, the tax treatment of health insurance is actually pretty popular, because most people benefit from it. So there's a lot of political opposition to changing the tax treatment. And as we tinker with the tax treatment of health care, we have to contend very directly with how that affects state insurance markets, risk pooling functions of insurance, and uncertain outcomes.

We'll hear first from Bob Helms, Resident Scholar at the American Enterprise Institute. He's going to talk about the history of the tax treatment of health insurance, and some possible reforms. Bob has written and lectured extensively on health policy, health economics, and pharmaceutical economic issues. He has been widely published and has held various government positions in the healthcare industry. So without further ado, Bob Helms.





MR. HELMS: Thank you, Amy. That's was actually a very good introduction for my talk. I think this is an area that's greatly misunderstood—maybe it's more like ignored—in the broader health policy debate and in the media.

One little illustration of this is that almost every reporter you talk to about the tax treatment or health insurance uses the word "tax deduction" when what we're really talking about is a tax exclusion. So any time you read something in the paper about eliminating a tax deduction, you should question whether what they are talking about a tax deduction or a tax exclusion.

Health policy, even tax policy, is certainly in the political debate today. The last I heard, we still have two Democratic candidates. There is a lot of information about these plans on the Kaiser family website, "Health08." Hillary is proposing an individual mandate, and Senator Obama is proposing an individual mandate for children. Most of the experts in this area think that all of the candidates' proposals are still very vague. And whoever gets elected will have to face the separate issue of getting something passed. But I'll just point out that there are a lot of details in the Clinton and Obama plans already about heavy regulatory proposals for private health insurance.

McCain's proposal is even vaguer. So far, he's proposing to end the tax exclusion, but to give everybody, regardless of income, a tax credit: individuals $2,500 and families $5,000. Recently, he referred to the Guaranteed Access Plan. This is something he would have to work out with states, as kind of a fallback position that people could opt into. He also proposes to allow the interstate purchase of health insurance.

There are no official estimates of the cost of any of these plans. The estimates on the Clinton and Obama plans are really done by the campaigns themselves, not outside scorers.

I want to highlight what we health economists think we know about health and health insurance markets. First, we're talking about a service that a lot of people think is not a normal commodity—still, prices in this market matter. They matter to the buyers; they matter to the sellers. We also know that insurance, whether it's public or private, lowers the perceived price to the consumer. In other words, we have what's commonly called a moral hazard problem: increases in volume demanded when people don't pay the full price out-of-pocket.

On the supply side, the delivery of health care is very labor-intensive. It's mostly services. But we do have a lot of products that are always changing. So innovation and investment, etc., are important issues in this market. And we have large capital investments, particularly in hospitals, nursing homes, etc., which make quick adjustments more difficult.

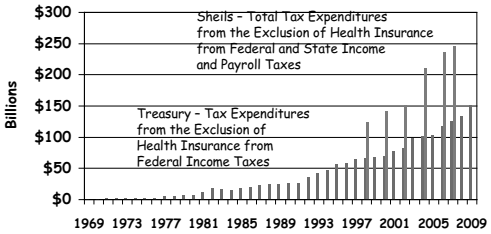
But what's common about both public and private programs is that almost all the payment policies we have are open-ended in various ways. I'm not going to talk about Medicare and Medicaid; they have their own open-endedness. But an open-ended policy creates strong incentives to increase spending. In other words, you're spending somebody else's money, and so your incentive to be careful about it is much weaker. The result is what Clark Havighurst and others have called "flat of the curve medicine." Basically, we invest up to the point where the marginal returns are very low, sometimes negative.

Now, I want to talk a little about history. The '30s, '40s, and early '50s were a period of great change in medical technology. Lots of new discoveries—in particular the development of penicillin, used with the troops in World War II, then made widely available after the war. This had the effect of making possible a lot of what we now consider to be routine surgery. Before that, it was more difficult because one could not keep down infection. So there were major advances not only on the drug side but also with regard to medical procedures. As a result, people began to value medical care more highly than they had in the '30s.

There are many statements in the literature that say something like, "In the 1930s the average physician could not affect the average condition of the average patient." That statement recognizes that there were lots of innovative things going on in medical schools, in the '30s. But the perception back then was, stay out of the hospital; it's a dangerous place. That's where people go to die. If you went there, you were probably going to get an infection. That changed, even by the '50s, so that people began to perceive of medical care as actually doing something good for you, even though it was expensive. This created a demand for insurance which allowed health insurance coverage to increase rapidly in the post-war period.

Early health insurance developed in the 1930s from early prepayment plans started in the Depression by hospitals seeking ways to get payment. These were organized by the American Hospital Association into the Blue Cross plans. Physician coverage developed later when the AMA helped to organize local plans into what became know as Blue Shield plans. The commercial insurance that we know today started in the private sector and were modeled after those plans. The AHA and the AMA went to the state legislatures and got a lot of legislation passed that made state Blue Cross and Blue Shield plans nonprofit and exempt from state premium taxes.

Tax Expenditures from the Exclusion of Health Insurance from Taxes, 1969-2009



Sources: OMB Special Analyses; John Sheils, The Lewin Group

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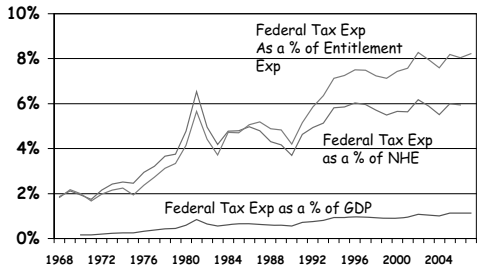
Federal Tax Expenditures as a Percent of GDP, NHE, and Federal Entitlement Expenditures, 1968-2007



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Then, World War II came along and with it a massive amount of economic planning and regulation. The government empowered a War Production Board to coordinate production of materials, and begin intensive government planning and price controls. The Office of Price Administration ran the rationing system and price controls of individual products. The National War Labor Board controlled wartime wages and attempted to settle labor disputes. In an effort to assure wartime production, they established many detailed rules and regulations regarding all aspects of hiring and paying employees. In 1943, the Board faced the problem of what to do about fringe benefits. In the end, they adopted the IRS rules and focused on controlling cash wages while exempting employer-provided fringe benefits, primarily pensions and health insurance. This was at a time when health insurance was relatively small and inexpensive.

After the war, the War Labor Board was disbanded but the IRS adopted the Board's policy of exempting fringe benefits from taxable income. It vacillated a little bit about whether employer-provided health insurance should be taxable or not, but the Congress finally stepped in and put this into legislation in 1954, saying that health insurance provided by the employer was to be excluded from taxable income. Now, that—the tax preference that Amy explained—combined with the increase in demand for health insurance led to rapid growth in health insurance coverage after the war. The post-war increase in the population, the influx of women into the marketplace, and income growth all combined to increase the demand for health insurance. The people who had hospital benefits increased from 12.3 million in 1940 to about 180 million in 1945; that is, nearly 90% of the population had health insurance of some kind (see chart 14).

Tax policy also influenced the form of health insurance. As you can see in chart 15, in terms of the millions of people covered by employer groups compared to individual coverage, the individual market did grow after the war. But the tax policy created a financial advantage for group, or employer-provided, coverage. Amy's reminder that there are advantages for risk pooling and so on also played a role in this. The tax policy was not the only reason for the growth of group coverage, but is provided the fertilizer to boost the growth of coverage in the employment sector.

Historical data from the 1960s to 2000 show that third party payments (also reflecting the growth of Medicare and Medicaid passed in 1965) increased relative to out-of-pocket payments. Out-of-pocket payments decreased from almost 60% to less than 20% from 1960 to 2000.

One of the conclusions I would like to leave you with today is that the present tax policy was somewhat of a historical accident. Still, it has played a large role in pushing health insurance into the employment sector and causing health insurance to evolve in an inefficient way.

Chart 18 shows two estimates of the growth of tax expenditures caused by federal tax policies that exclude employer-provided health insurance from taxable income. The measurement of tax expenditures is a controversial topic, but I use them because they are a convenient statistic and the only way I know to illustrate the effect of tax policy over time. The green bars plot the Treasury Department estimates over time and you can see they have grown. John Shiels at the Lewin Group has an alternative estimate that includes the effects of payroll taxes and state taxes. His estimate is almost up to $250

billion a year in 2007. Note that on the basis of the Sheils's estimates, total federal and state tax expenditures are increasing on average over $13 billion a year from 1998 throught 2006. If this lost revenue to the federal and state budgets had been from expenditure increases, it would most likely have received more attention.

Now, how does this compare to the economy? I've taken just those estimates of federal tax expenditures and compared them to three measures of economic activity (see chart 19). Tax expenditures are growing—relative to gross domestic product, as a percent of national health expenditures, and also as a percent of entitlement expenditures in the federal budget. So it's increasing relative to almost anything you put in the denominator. The effect of tax policy has been to push the demand for health services to a higher equilibrium than it would have been without the tax subsidy. To summarize, the effects of tax policy intensified the effects of increases in income, population, and medical technology; it expanded employment-based insurance relative to the individual insurance market; and it expanded insurance benefits, meaning it gave an incentive at the margin, so that people have more hospital coverage, more outpatient care, and eventually mental health, dental, and drug coverage, etc. Some people even include exercise programs now. And if you can get your employer to include these things, you get it tax-free. Another point to remember about the exclusion is that the higher your marginal tax rates, the higher the benefit is to you. Tax policy induced a higher level of costs, prices, and expenditures and created winners and losers.

Let me close with a comment on the health reform debate. This is oversimplified, but in my view you have two basic approaches to reform. You can take a tax reform approach—which, to me, is a necessary condition to the effective reform of incentives. If tax policy pushed us into an inefficient form of insurance, then it seems to me that we've got to change it somehow, maybe put a limit on it with a tax cap to give incentives for people to redesign these plans and put more emphasis on value and cost effectiveness. You could eliminate the tax exclusion, put on a tax cap, as in the 1940s during World War II. That was actually proposed under the Reagan administration, something I was involved in. Bush had a standard deduction proposal, and McCain has a tax credit proposal that would eliminate the tax exclusion but give people a deduction or a tax credit. Under this system you would have strong incentive to redesign the health insurance coverage. You'd have more research on cost-effectiveness. The market would then determine which kind of health policy would dominate, but you'd have, I think, more cost-effective options for small businesses, which is where a lot of the uninsured are now. This is a necessary, but not sufficient, condition for effective reform.

The alternative is the regulatory approach, more administered fee schedules like we have in Medicare, more global budgeting, as Hillary Clinton proposed in 1993. You'd have mandated benefits like both of the Democratic candidates are proposing. You could mandate coverage for individual employers. You'd have a lot more underwriting restrictions, price controls on insurance, and mandates on the pay-out from insurance, which to me is just a form of price controls. If we take the regulatory approach, it will be important to remember that it will be much easier to mandate insurance *coverage* than it will be to mandate that everyone have *access* to high quality and cost-effective care.

Thanks.

PROF. MONAHAN: Thank you, Bob. Our next panelist is Michael Cannon, the Cato Institute's Director of Health Policy Studies. Prior to joining Cato, he served as a domestic policy analyst for the U.S. Senate Republican Policy Committee and is widely published in health care policy.

MR. CANNON: Thank you, Amy. And Bob, I want to let you know that I'm on my own campaign to change the way people talk about not just health care but taxes generally—I'm trying to eliminate the term "tax expenditure" from our vocabulary. Tax expenditure is how we describe money the government leaves with you. We call it spending. They're also referred to as subsidies. I don't think you can spend money or subsidize someone unless you actually have that money in your hands and then give it to someone else. I fear the day the government begins to consider all of the money it lets us keep as a tax expenditure and then decides, "We're spending it here, let's just spend it somewhere else instead." Anyway, the campaign goes on.

I want to thank Amy and Bob for really laying out most of the important issues surrounding tax reform and health care. I would add that there are also exclusions for money put into a flexible spending account: a health reimbursement arrangement or a health savings account (HSA). These are all accounts that let the individual consumer control the money, but HSAs are really the only ones that create ownership because only with HSAs do you get a tax break for money that you own and can take with you from job to job. And there's also the tax deduction for qualified medical expenses in excess of 7.5% of adjusted gross income.

Once you add the loss of revenue under the payroll tax, the tax exclusion for employer-sponsored insurance is about two times that of the next biggest revenue loser, which is the mortgage interest deduction. The exclusion distorts the prices and costs when workers are making decisions about how much health insurance to buy, where to buy it, and how to pay for their medical needs generally.

It distorts the prices or the costs that workers face in three different ways. First, it distorts the relative cost of health versus non-health expenditures. You've got a tax break for employer-sponsored health insurance. That's going to reduce the cost of health care spending generally relative to non-health expenditures.

Second, it reduces the cost of third-party insurance relative to self-insurance, because if you decide to get less generous coverage through an employer—(your employer makes that decision)—and save a bit of money, or put aside those savings on premiums to help pay for your medical bills, traditionally that money was taxed. So it wasn't a level playing field between those two decisions, between premiums and savings. With HSAs and some of those other options, the playing field has been leveled

somewhat, but not completely, because it only happens within a narrow range of premiums and deductibles, and it only works for people who purchase a qualified high-deductible health plan that's compatible with an HSA.

Third, the exclusion favors employer-sponsored insurance over other forms of third-party insurance. This could be insurance that you purchase on your own or through a group. The way that works is employer-sponsored insurance is favored to such an extent that if you decide to purchase insurance on your own rather than through an employer, depending on your health status and your tax bracket, you can end up paying twice as much for the same or less coverage—twice as much because you'd be paying higher taxes.

So what does this do to our health insurance market? Well, I think a lot of individuals end up getting stuck with insurance that doesn't meet their preferences. In the 1990s, as a response to the growing cost of health insurance, employers tried to move a lot of their workers into managed care. A lot of workers didn't like that. Right now, we're seeing a shift toward more cost-sharing in order to hold down the rising health insurance premiums. And I think we are seeing evidence of a similar backlash from consumers who would rather have less cost-sharing. So no matter what employers do they're going to step on some of their workers' toes.

As Bob and Amy mentioned, we end up encouraging people to obtain more coverage than they would if they were making decisions undistorted by the tax code. And they end up purchasing a lot of low value medical care. Economists have generally found that beyond a certain amount of health insurance, purchasing additional coverage doesn't deliver additional improvements in health. So that's one way of measuring value, but there are other ways that suggest that this excess coverage encourages consumers to purchase too much medical care.

It can also create inefficiencies by distorting people's labor market decisions. If you've ever heard of the term "job lock," that's when someone's got an employer-sponsored health insurance plan that they really need because they or someone in their family have a high cost condition, and they're afraid of moving to another job because that doesn't offer as generous coverage, or because they're afraid of retiring early and losing access to that coverage.

It also creates a lot of inequities, both horizontal and vertical. Say you've got two neighbors and they are identical in every way, except that one of them works for an employer that offers health insurance and the other does not. The one that does not ends up paying higher taxes because his health-insurance premiums are not tax-exempt. So it treats like people differently. A lot of people think the tax exclusion for employer-sponsored insurance creates vertical inequities as well. People with higher incomes get a larger tax break under the exclusion because they're in higher tax brackets. That's how deductions and exclusions work. People who are in lower tax brackets get smaller tax breaks, and because they're also less likely to work for an employer that offers employer-sponsored health insurance, they're less likely to get any tax break at all.

There is an interesting and underappreciated feature to the exclusion from employer- sponsored insurance. If you look at where the money comes from before it enters the hands of a doctor, insurance company, or anyone else operating in the health sector, almost half of it comes from the government, and over a quarter of it from employers, which means that, generally, employers are the ones controlling and deciding how it is used. The consumer share is only about a quarter. It's really less than that because that 26% includes things like Medicare Part B premiums, where the consumer doesn't really have much of a choice about how to spend it. Also, with regard to the employee portion of their employer-sponsored insurance premiums, if they decided to buy health insurance elsewhere, they could end up spending twice as much for less coverage. So the exclusion actually gives employers control over a large chunk of what is actually the employee's compensation. This is compensation that the employee earned. The economists tell us that the employer wasn't providing health insurance, that they would have to return that money to the employee in the form of cash wages—(or other benefits, but likely cash wages)—and that's a substantial chunk of earnings that the employer gets to control. An average family policy offered through an employer costs $12,000.

On average, the "employer portion" of that is $9,000. That's a substantial chunk of money for most families that the employer gets to control, and it's why, if you look at only the private sector, employers control about half the money that goes into health care from private payers. There are two reasons for that. The first is the wedge that the exclusion drives between the worker and their earnings, and the second is the fact that, by drawing so many people out of the individual health insurance market, it makes a much thinner market and one much less attractive to people who might like to purchase insurance that meets their own needs.

We've talked a little bit about possible reforms. There's leveling up and leveling down. Limiting health-related tax breaks would be leveling down, and there are a couple of ways to do that. You can cap the exclusion so that if you have a family policy with premiums of $12,000, and we placed a cap of $6,000 on the exclusion, then the worker would have to pay taxes on the $6,000 that exceed that count.

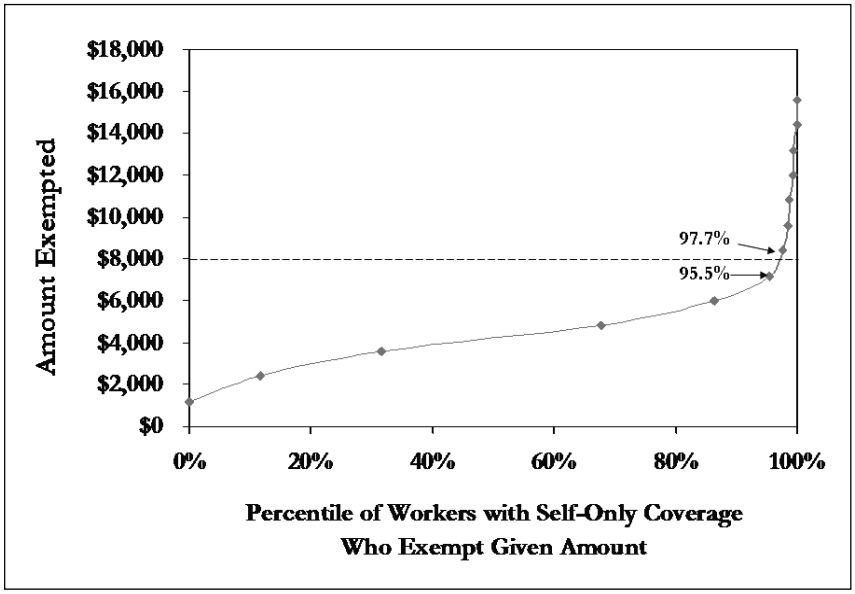
You could also eliminate the exclusion, which by itself would be a large tax increase because you'd be taxing a lot of previously untaxed activity. So usually when people talk about eliminating the exclusion they talk about reducing marginal tax rates so that it would be revenue-neutral.

You could also expand health-related tax breaks. Health savings accounts did that. Actually, they have done it twice so far: by creating a tax-free account, where you get a tax break for money the consumer controls; and again in 2006, they ramped up the amount of money that people can put into a health savings account tax-free. Both actions expanded health-related tax breaks.

Another option that has been proposed is full deductibility of all health spending. Now here I do mean deductibility. The authors of this idea propose allowing individuals to deduct from their income taxes every dollar that they spend on health insurance premiums and every dollar that they spend on medical care out-of-pocket. It also would expand the tax breaks as they exist.

Then there are some hybrid approaches that would broaden the existing tax breaks but still limit them in some way. Those include the tax credits Senator McCain has proposed and the standard health insurance deduction the President proposed.

I want to throw out on the table another option that actually builds on health savings accounts. This falls into the hybrid category. Like the others, it would expand the tax breaks, but cap them at the same time. So over time it would limit these tax breaks relative to what they are under the current law. I call this option large health savings accounts. Essentially, it would build on HSAs and replace the exclusion from employer-sponsored insurance. First, it would essentially triple the HSA contribution limits to $8,000 or $16,000 for individuals and families respectively (those aren't magic numbers; for political reasons they might need to be higher or lower). The second thing it would do to HSAs is remove the insurance requirement. Right now, you can only put money in an HSA tax free if you have a qualified high-deductible health insurance plan. There are reasons for removing the insurance requirement that I will get to. Lastly, it would allow people to purchase any kind of insurance from any source with their tax-free HSA funds. Currently, you can only use HSA funds for insurance premiums under limited circumstances.



Before I get to how they would do it, how would large health savings accounts work? For the most part, workers could take 100% of the money they currently exempt from income and payroll taxes as a tax-free large health savings account contribution. So the family that has a $12,000 policy through their employer could put the $9,000 their employer was paying into a large HSA, and put $3000 in, and the taxes would not go up. They could even put in $4,000. They could adjust that amount, as workers can with flexible spending accounts now. And, as I mentioned, they could purchase insurance from any source, or no insurance. There are people who would not be able to arrange this sort of payroll deduction, but there's a way to give those people an equivalent tax break. The President laid out that option solution when he proposed standard health insurance deduction.

So, if we made these three changes, how would it change the tax treatment of employer-sponsored health insurance? Well, you remember the three price distortions I mentioned earlier. It would completely eliminate the last two. It would retain a distortion between health and non-health uses of income, but because you would get that tax break for putting the money aside for your health care needs, it would eliminate the price distortions between third-party insurance and saving, and it would eliminate any distortion between consumers' decisions to purchase employer-sponsored insurance or insurance from another source. And like I said, it would broaden and cap the tax breaks. It would cap them because those contributions would effectively act as the cap on what is currently an unlimited exclusion. And if those were held constant in nominal terms or even in real terms, those contribution limits would reduce the tax break over time.

Large HSAs would allow people to purchase the mix of insurance and saving that is right for them. It would allow them to purchase the type of insurance that meets their needs, and allow them to choose between high-deductible health plans or health plans with lower deductibles, health maintenance organizations, preferred provider organizations, and fee-for-service or prepayment. And because when people are actually facing the cost of the premiums they are purchasing, they're more likely to reduce the amount of health insurance they purchase, that would reduce the consumption of the low-value care we mentioned before. It would also reduce labor market distortions, because there would be a level playing field for individual insurance. Fewer people would be stuck in jobs because their insurance would stay with them.

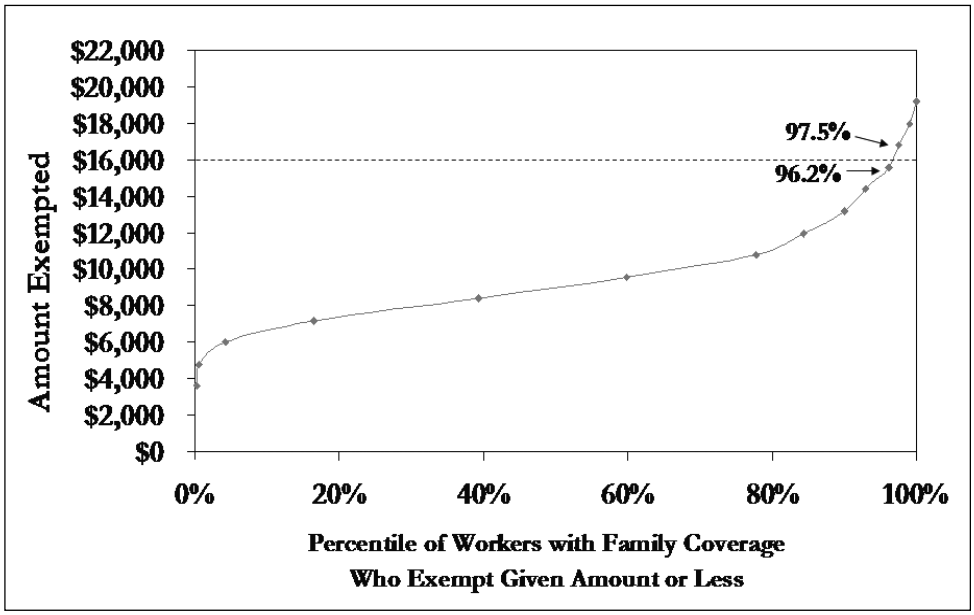
In terms of horizontal equity, it would eliminate the tax penalty currently imposed on people who don't get employer-sponsored insurance, so people would no longer be penalized based on the place of employment or the quantity of coverage they purchase and where they purchase it.

It is a little less clear what it would mean in terms of vertical equity, but I would argue that for those who are very concerned about vertical equity, large HSAs would be an improvement. First, they would cap the exclusion so that the wealthy would be less able to take advantage of these large tax breaks for health insurance and would extend a tax break for health care to low-income workers who currently get none.

Importantly, almost every proposal to reform the tax treatment of health insurance focuses on providing a different tax break for health *insurance*. What does that mean if you're uninsurable? If you're only providing a tax break for health

insurance, people who are uninsurable don't get any tax break. This is true of the President's proposal for a standard health insurance deduction, proposals to cap the exclusion for employer-sponsored insurance, and McCain's tax credit proposal. One benefit of a large HSA approach is that it actually provides a tax break for health *savings*, rather than health *insurance*, so that the uninsurable get a tax break, the same break the insurable get.

And I think it would be a more feasible way of capping the exclusion than most of the other proposal that we've seen. One of the recurrent obstacles to reforming the tax treatment of health insurance is that they pretty much all involve taxing previously untaxed economic activity. Large HSAs deal would let almost every worker get the same tax break they're currently getting. The first chart here (opposite) shows the cumulative distribution of how much of earnings workers exempted in the form of employer-sponsored health insurance in 2006. Now that line at $8,000 represents the proposed large HSA contribution limit. And you can see that about 97% of all workers exempted less than $8,000 in the form of employer-sponsored insurance. What that means is that, by replacing the current exclusion with large health savings accounts, 97% of workers would see no tax increase. In fact, they may see a tax only if they wanted to purchase more generous insurance than they get right now. Only 3% of workers would see any possibility of a tax increase in the first year. Offsetting that potential tax increase, is the control they would get over the first $8,000 of their earnings, which is really a tax *cut*. The second chart (above) is the same, but for family coverage, and it shows basically the same thing, with a contribution limit of $16,000. Ninety-seven percent of workers who currently have employer-sponsored family coverage would see no increase in their taxes. And these are just another two ways of looking at that, showing the frequency distribution for those with self-only coverage and family coverage.



It can be likened to a tax cut, even for that 3%, because it gives them more control of the first $8,000 or $16,000 of their spending. And it would also make it easier to move toward a tax system that's completely neutral toward health expenditures.

There are some potential negatives, but those exist with all approaches for reforming the current approach to taxing health insurance. What is the effect on federal revenues? What are the effects on pooling? If you level the playing field between employer-sponsored insurance and individual market insurance, will that encourage low-risk people to leave the employer-sponsored pools, and therefore increase premiums for the high-cost people in those pools? Large HSAs create a potential problem with regard to free riding because people may decide they just don't want to purchase health insurance. Many of these potential negatives are smaller than they appear, and others can be mitigated by adjusting things like large HSA contribution limits. In my view, large HSAs would be less disruptive to people's health insurance, and would do more for the uninsurable than any other approach to reforming the tax treatment of health care. And I'll go ahead and stop there, and hopefully we can talk about those in the question-and-answer portion if there's any interest.

Thank you very much.

[Discussion and Q&A available in recording online.]