The Intersection of Tax and Health Care Policy

Abstract - This paper discusses integrated proposals for health care reform that combine changes to the tax treatment of employer-sponsored insurance to improve incentives with insurance market reforms to address problems in the individual market for health insurance. Combining these two types of measures is essential to slowing the rapid increase in health care costs while taking heed of the potential acceleration of the already ongoing contraction of the employer market that would occur with changes in tax policy alone.

INTRODUCTION

Health care spending continues to rise rapidly in the United States, consuming a greater share of households’ disposable incomes. The growth in health care costs has exceeded GDP growth by two percentage points annually since 1940, with the share of health care spending rising from 5.3 percent of GDP in 1960 to 17 percent in 2009—and with a further increase to roughly 20 percent of GDP expected by 2017 (Congressional Budget Office, 2008). As health care costs grow faster than households’ incomes, an increasing number of individuals are unwilling or unable to purchase health insurance, with the latest estimates indicating that 45 million people are without health insurance at some point over the course of a year, That figure is expected to rise to 54 million by 2019 (Congressional Budget Office, 2008).

Public spending on health care through the Medicare and Medicaid programs is also expected to grow faster than both the overall economy and the revenues available to fund these programs under current law. This so-called entitlement problem poses a substantial fiscal challenge for the United States. While federal government spending before the temporary stimulus in early 2009 comprised about 22 percent of GDP, federal government spending is expected to grow to over 42 percent of GDP by 2050 in a scenario in which politically popular programs are extended (Congressional Budget Office, 2009). An important aspect of the entitlement problem is that it is not likely to be politically feasible (or economically desirable) to raise the additional revenue to meet the growth in the Medicare and Medicaid programs. Even if taxes are increased to provide additional revenues, measures to slow the growth of health care costs will be required as well.
Progress on this front will help address fiscal pressures as well as the problem of the uninsured, which to some degree is related to rising health care costs.

The key to addressing the problems of rising health care costs, the uninsured, and the rapid growth in entitlement spending, is to bring the growth in health care spending—both private and public—in line with the growth in disposable income and the underlying economy. While changes to the Medicare and Medicaid programs will be elements of a solution, a change in the tax treatment of health care that improves incentives to control health care spending is likely to be at the core of a health care reform program.

The United States spends roughly $300–$400 billion annually on health care through the tax code—this is implemented as an exclusion of employer-provided health insurance, but should be viewed as spending that happens to be done through the tax code (U.S. Office of Management and Budget, 2009). This large tax subsidy has contributed to the rising cost of health care by affecting how health care is purchased and financed (Gruber, forthcoming). Reforming the tax treatment of health care, however, may accelerate the already ongoing contraction of the market for employer-provided health insurance. Thus, any substantial change in its tax treatment also requires a set of complementary insurance market reforms to address the problems of individual underwriting and adverse selection that might hinder the development of a well-functioning individual market for health care insurance.

This paper considers reforming the tax treatment of health care insurance, but also recognizes the need to address important weaknesses in the individual market. The next section discusses the current tax subsidy and its effects on the functioning of the health care market. The third section discusses the impact of reform on the employer market and the fourth section discusses the need for complementary reforms of the individual insurance market. The fifth section outlines five specific approaches for insurance market reform. The sixth section concludes the paper.

THE TAX TREATMENT OF HEALTH CARE

The United States spends roughly $300–$400 billion annually on health care through the tax code. This tax subsidy, which takes the form of an exclusion for employer-sponsored health insurance (ESI), has shaped health care markets in the United States since the end of World War II and affects incentives in ways that have increased the level of health care spending. The value of the tax subsidy to a taxpayer generally increases with how much an individual spends on health insurance, which in turn relates to how much an individual spends on health care. The deduction rewards pre-funding routine health care through employer-sponsored insurance, and favors employer-sponsored insurance over insurance purchased directly by individuals. The value of the subsidy also rises with the taxpayer’s income and thus marginal tax rate, which means that a disproportionate share of the benefits go to middle and upper income taxpayers. The result is a health insurance market dominated by low-deductible employer-sponsored health insurance with generous coverage that dulls consumers’ sensitivity to the price of health care. While many factors affect health care spending, the tax deduction for ESI has likely contributed

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1 This estimate is the average annual cost from 2010–2019 and includes the exclusion of employer-sponsored health insurance for purposes of both the income and payroll taxes.
to the rising growth in per capita health care costs (Newhouse, 1993).

One benefit of the tax subsidy is that it encourages the purchase of insurance through employers, and thus provides a natural mechanism to pool health risks across workers (Burman et al., 2007). This risk pooling allows for cross-subsidization based on health status and results in lower health insurance premiums for people with poor health status, since they are supported by having younger, healthier coworkers pay higher premiums than would otherwise be the case (i.e., if premiums were actuarially fair). Nevertheless, despite the large tax subsidy and this pooling mechanism, the current system has left 45 million people without insurance and health care costs continue to rise rapidly.

Various proposals have been put forward to reform the tax treatment of health care, such as capping the exclusion for ESI, replacing the exclusion with a flat credit or deduction, or extending the favorable tax treatment to all types of insurance and health care spending (Carroll, 2007; Cogan, Hubbard and Kessler, 2005). These proposals have the potential to dramatically improve incentives in the health care market. Replacing the existing exclusion with a flat credit that is available to everyone who purchases a qualifying health insurance policy, for example, would provide a strong incentive to purchase health insurance while breaking the link between the tax subsidy and the amount of health care spending.

IMPACT ON THE EMPLOYER MARKET

Reducing or eliminating the tax bias that encourages the purchase of employer-sponsored insurance (i.e., leveling the playing field between the employer and individual health insurance markets) would likely accelerate the already ongoing decline of the employer market. The most aggressive reform—complete replacement of the existing exclusion for ESI with a flat credit—has been estimated to reduce the number of people purchasing insurance in the employer market by over 30 million (Lewin Group, 2008). This means that the net impact of reform proposals in reducing the number of uninsured depends on whether individuals who no longer purchase insurance in the employer market would instead purchase insurance on their own. Moreover, as many as an estimated 25 million people would not purchase health insurance even with the flat credit proposal taken in isolation, presumably because their premiums would substantially exceed the amount of the credit.

The net effect of a potential health care reform package depends on both the size and design of the credit and on ensuring that the individual market for health insurance has the capacity and features to support an influx of people seeking to purchase health insurance. There is reason to think that the individual market alone might not provide for the adequate pooling of risk. Individual underwriting means that the market is susceptible to adverse selection, as healthy individuals choose to not purchase insurance or to move to lower cost pools, leaving those with poor health status with higher premiums or unable to afford insurance. Indeed, a key element of any substantial change in the tax treatment of ESI is implementing a complementary set of policies that would support a well-functioning individual market; in particular, these policies would address the potential problems of individual underwriting and adverse selection.

APPROACHES TO STRENGTHEN THE INDIVIDUAL MARKET

The individual health insurance market must deal with underwriting and adverse selection, which hampers high risk individuals’ ability to purchase and
maintain affordable health insurance coverage.\(^2\) When an individual purchases insurance in the employer market, those with poor health status are subsidized because premiums are set based on the risk profile of the employer pool, not the individual. Thus, in the employer market, there are in effect “hidden” subsidies across individuals based on health status. In the individual or nongroup market, an individual is much more likely to face premiums determined by their individual risk profile; that is, the cross-subsidization that characterizes the employer market is generally absent from the individual market.

Efforts to improve the functioning of the individual market generally include removing distortions that raise costs while providing resources that reduce the costs faced by those with poor health status and possibly low incomes. In effect, the goal is to ensure that people with high expected health costs do not pay the full actuarial cost of coverage. This can be accomplished in two ways. First, those with poor health status can simply be subsidized through a system of “above-the-table” transfers that provide assistance to hard to cover or lower income individuals. Alternatively, one group (i.e., the healthy/high income) can be compelled in some less transparent way to subsidize another group (i.e., poor health status/low income).

Thus, some reforms might entail large infusions of public funds, while others internalize (that is, hide) the cost of the subsidies to the covered population, perhaps through mandates and some type of community rating. Other related issues include whether the reforms provide incentives for coverage (i.e., “carrots”) or penalties for lack of coverage (i.e., “sticks”), and whether the delivery of the subsidies is primarily a state or federal governmental function. Regardless of whether affordable access is provided at the federal or state level, the following five approaches are likely to be considered as potential ways of meeting policy goals.

### High-Risk Pools

High-risk pools provide access to health insurance for people with high expected health care costs who are rejected by traditional insurers. States fund these pools from general revenues or taxes on insurance premiums. In practice, these risk pools are subject to stringent eligibility requirements (such as exhaustion of COBRA coverage) and have limited financing. If this strategy were adopted as a policy to deal with widespread loss of coverage in the employer market, additional funds would be required to cover the costs of the pool. There are tradeoffs in keeping the costs of high risk pools down and expanding eligibility to ensure access to affordable coverage. One appeal of high risk pools is that they use a structure that is already in place. Also, because they do not impose regulations on the market as a whole, they do not induce new market distortions. Rather, the subsidies are above-the-table.

The high-risk pool policy approach is primarily used to make insurance more affordable for high risk individuals (hence the name), but it can also be targeted to people below certain income thresholds by limiting eligibility based on income. In that case, subsidies would be more narrowly targeted to people who are both

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\(^2\) There is some debate regarding the size of the problem. Some argue that guaranteed renewal of policies provides ample protection of people in the individual market once they become predictably high risk. But studies of the individual market have limited applicability in predicting the functioning of the market if it is considerably larger as a result of the tax credit. As it is now, group coverage is relatively easy to substitute for individual coverage; if the tax treatment between individual and group coverage is equalized, people may find it harder to find group coverage if appealing alternatives in the individual market do not materialize.
low income and high risk. Such targeting might be a natural counterpart to eventual reforms of Medicare and Social Security that will tend to move those programs in the direction of means-tested benefits, where the means testing is done on the basis of lifetime earnings.

Risk- and Means-Tested Vouchers

Another approach is for the federal government or states to directly subsidize premiums for people of high risk and/or low income. Income qualifications would be determined annually. Risk qualifications would be determined when an individual purchases insurance.

The information used to underwrite premiums could also be used by the states, in conjunction with information on the individual’s means, to determine a subsidy that the individual could use to help cover insurance premiums. The subsidy would increase for individuals with lower incomes and higher risks. Each year, the individual would re-submit income information to determine the qualification. Only when the individual changes health insurance would the risk component of the subsidy be re-evaluated, because once an individual purchases insurance, he is not re-rated within the risk pool.

This is an above-the-table subsidy. Vouchers allow for very specific targeting of aid. Unlike other policies, vouchers would limit the cross-subsidization of low income, low risk people to high income, high risk people. States would also have the flexibility to incorporate vouchers into existing regimes. A state with significant rate regulation could only allow subsidies based on income, while states with light regulation could primarily target high risks, given that the tax credit will make insurance affordable for low income people who do not face high health insurance premiums (such as young adults).

The primary drawback of this approach is its complexity. A government entity administering the voucher system would have to collect income and health information on all applicants for insurance. Ensuring that this information is accurate would be crucial, because the amounts of the subsidy would likely create significant incentives for individuals and insurers to game the system. Because it does not require any cross-subsidization from low risk to high risk individuals, the policy could require substantial sums of public dollars. These funds could be generated in part by scaling back the level of the tax credit, that is, by using some of the current tax expenditure on ESI. This would in effect lessen the “penalty” for not purchasing insurance—the amount of money an individual leaves on the table by not purchasing insurance. The impact of this on insurance take-up would be an empirical matter to be investigated. Also, a working model of this approach does not exist, making it a potentially risky experiment to undertake.

Premium Regulation

Premium regulation sets the maximum amount that insurers can vary rates by age or health status. The most extreme form of premium regulation is community rating, in which everyone is quoted the same rate, regardless of age or health status. Premium regulation forces provision of affordable insurance products to high risk people. It is one of the under-the-table approaches to subsidization. Because the forced cross-subsidization occurs within the insurance market, it does not require outside funds. In a premium-regulated system, healthy people pay in excess of actuarially fair prices, and sick people pay less than the actuarially fair price for coverage.

One appeal of this approach is its familiarity and ease of implementation; community rating, along with subsidies, is used almost universally in the group market and Medicare. Massachusetts’ efforts
to achieve universal coverage, perhaps the most realistic universal coverage effort ever in the United States, are anchored on significant rate limitations.

Adverse selection is a significant issue when premium regulation is used. Young healthy people would try to detach themselves from cross-subsidizing older, unhealthy people by opting not to be insured or looking for insurance policies that would be unappealing to older, unhealthy people. The incentives to segment risks might result in worse care, lower overall coverage and rapid premium growth, particularly for the chronically ill. To combat the effects of adverse selection, states could implement additional policies, such as an individual mandate, to require all individuals to hold insurance coverage and supplement premium restrictions with subsidies to insurers based on risk adjustment.

This approach focuses exclusively on ensuring affordability for high risk individuals. Because premium regulation (especially in the absence of a strong mandate) generally raises the average premium, an additional premium assistance program for low income people is necessary if coverage of individuals with low incomes is a concern.

**Risk Adjustment**

Risk adjustment is a mechanism that spreads the cost of insuring predictably high risk individuals. Insurers are subsidized for insuring beneficiaries with certain characteristics, such as presence of chronic disease or history of poor health. The subsidy corresponds to the difference between the predicted claims costs of those individuals and some baseline cost. This could be implemented as a below-the-table subsidy in which subsidies provided by low risk individuals in the form of higher premiums effectively finance the resources going to others with high risks. Alternatively, there could be a system of subsidies funded with public resources and no levy, implicit or explicit, on those who do not receive a subsidy based on risk- and needs-adjustments.

In principle, full risk adjustment would make an insurer completely indifferent between having a high risk enrollee and a low risk enrollee, because on net their costs would be the same. In practice, however, this would be difficult to achieve. A risk adjustment scheme can be more limited in scope, such as by compensating insurers only for very high risk individuals (and perhaps correspondingly charging them a fee only for very healthy insured enrollees).

To implement a risk adjustment scheme, either states or the federal government would establish a program to collect medical encounter data from all insurers and process the data to estimate projected expenditures for all insured people. The risk adjuster would then draw from a pool of funds, financed by low risk individuals via their insurers, to cover the projected expenditures in excess of baseline expenditures for each insured individual.

The purpose of this policy is to limit premium variation by eliminating the variation in predicted health care expenditures. If insurers do not have to bear the risks of enrollees with predictably high expenditures, they would not charge high premiums to those people. The approach also keeps risk pools from deteriorating, because a pool would be compensated for worsening experience.

The major drawback to this approach is its administrative complexity. To ade-

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3 If the risk adjustment was done prospectively, there may still be groups of people insurers would like to avoid. If the risk adjustment were based on the prior year of medical claims, this would not take into account a heart attack or cancer from two years’ prior. Thus, the insurer would bear the risk of that individual having a repeat episode, because the risk adjustment would not subsidize that risk.
quately risk adjust, a great deal of data would have to be collected, verified, and protected. However, risk adjustment software exists and is being used in Medicare Part D and Medicare Advantage. Another drawback is the scope of the subsidies. Because people with predictably high risks account for a large share of health care expenses, adequate risk adjustment could require very large transfers to finance the program.

Although risk adjustment reduces incentives to segment risks between plans, average premiums could be quite high. Thus, low risk individuals may need additional incentives, including possibly a mandate, to purchase insurance at the outset and an additional premium assistance program for low income people would be necessary if low income coverage is a concern.

Reinsurance

Reinsurance pools absorb catastrophic levels of claims from insurers. In a typical model of public health reinsurance, insurers designate enrollees, either prospectively or retrospectively, whose claims will be covered by the reinsurance pool. The reinsurer covers a substantial portion of claims for individuals whose claims exceed a certain threshold. The external financing needed can be provided by general revenue or through premiums on participating insurers. Many states maintain reinsurance pools for their small group and/or individual market, but the usual purpose of reinsurance is to help stabilize health insurance markets by providing relief to insurers with deteriorating risk pools.

This is an above-the-table subsidy. Reinsurance is a somewhat crude way to ensure access for high risk individuals, because it provides subsidies for claims both of those who were predictably high risks and those who were predictably low risks. To keep the cost of reinsurance pools manageable, thresholds are set high—claims above $50,000 or more, for instance. By itself, reinsurance structured like this would not ensure that people with predictably high risks would get affordable health insurance. The insurer would still be on the hook for covering high claims costs of people with predictably high risks, so the insurer would still want to charge relatively high premiums. It might also be gamed by providers and insurers. If insurers are not responsible for a substantial share above the threshold amount, they may not demand that providers treat people with catastrophic costs efficiently.

Other Considerations

Aside from the five specific tools to deliver subsidies to target populations, two other issues would need to be considered: (1) what constitutes acceptable or qualifying health insurance coverage for purposes of any subsidy, and (2) whether a connector-like mechanism should be used to facilitate the operation of the individual insurance market.

Qualifying Coverage

The federal government has little experience in defining qualifying health insurance for purposes of a policy intervention, as the states bear the greatest burden in regulating health insurance. In defining the characteristics of a basic affordable policy, several models have been suggested:

- **HSA qualification.** HSA qualification is determined by cost-sharing amounts—deductibles and out-of-pocket limits. HSA regulations do not describe what kinds of benefits must be covered. HSA qualification could be used to set minimum or maximum cost-sharing amounts.
- **FEHB qualification.** The Federal Employees Health Benefits Program has a list of benefits participating...
insurers must cover. Insurers must cover benefits equivalent to what most group plans cover, including prescription drugs. Some would argue that a basic policy should not include benefits like prescription drugs, which would make the cost of the basic policy cheaper. Also, although FEHB plans are similar to other group plans, many would argue that the typical group policy provides excessive health insurance coverage.

- **Mandate free health insurance.** Specifying that a basic health insurance policy not include state-mandated benefits would satisfy those who feel like benefits mandates drive up the cost of health insurance for unnecessary benefits. Yet the federal government would then have to determine whether some mandated benefits, like maternity coverage and mental health, should be exempted.

- **Mini-Med.** Nearly the opposite of HSA-qualified health insurance, mini-Med would provide coverage for low levels of expenses, but cap insurance coverage at an amount like $25,000. Because health care expenses are concentrated at the tail end of the distribution, this relieves the insurer of the responsibility of a large share of potential claims. However, this is not real insurance and would be of little value to people with expenses greater than the cap in coverage.

- **Cross-state insurance.** This would allow insurers to sell policies from jurisdictions with more favorable regulatory environments to people in other states, potentially lowering the cost of health insurance to people in heavily regulated states. However, allowing low risk individuals to seek coverage in states that limit cross-subsidization could thwart state-level efforts, such as in Massachusetts, that rely on cross-subsidization to achieve universal coverage.

These characteristics are not mutually exclusive and need not apply to all policies in the market. Rather, the federal government may want to require states to employ one or more of these approaches in order to enhance access to insurance coverage for qualifying state residents.

**Mechanism for Delivering Health Insurance (Connector)**

To deal with a reduction in employer sponsorship of health insurance policies, the federal government may want to establish or require states to establish a mechanism through which people can take advantage of the administrative savings of the group market without actually working for an employer that sponsors health insurance coverage. Such a mechanism, called a Connector in Massachusetts where one is in operation, allows employers to submit premiums through payroll deductions and sends them on to insurers. It must be emphasized that a Connector is simply an administrative tool to relieve employers of some of the burden of offering employees health insurance. In Massachusetts, plans are heavily regulated, so people applying for health insurance through the Connector cannot be rated according to health characteristics. However, a Connector could be placed in a less regulated market. In this case, an employer could still take advantage of the Connector’s administrative tools, but individuals may still be rejected for coverage or charged premiums according to risk. If the federal government would like to include Connectors in its reform plan, it needs to understand that by itself this would do little to affect access to health insurance by targeted populations.
CONCLUSION

The existing tax exclusion for employer-sponsored health insurance has had a fundamental effect on the structure of the health care market in the United States and has likely contributed to the rapid growth of health care spending. Reforming the tax treatment of ESI to limit the role of taxes in health care decisions, however, could accelerate the unraveling of the employer market. An alternative approach is to combine reform of the tax treatment of ESI with insurance market reforms to address the problems of individual underwriting and adverse selection in the individual market, reforms that are essential to slowing the rapid increase in health care costs. In addition, this approach would mitigate the potential acceleration of the ongoing contraction of the employer market that would occur with changes in tax policy alone.

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