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Federal Tax Incentives For Health Insurance

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Federal Tax Incentives For Health Insurance

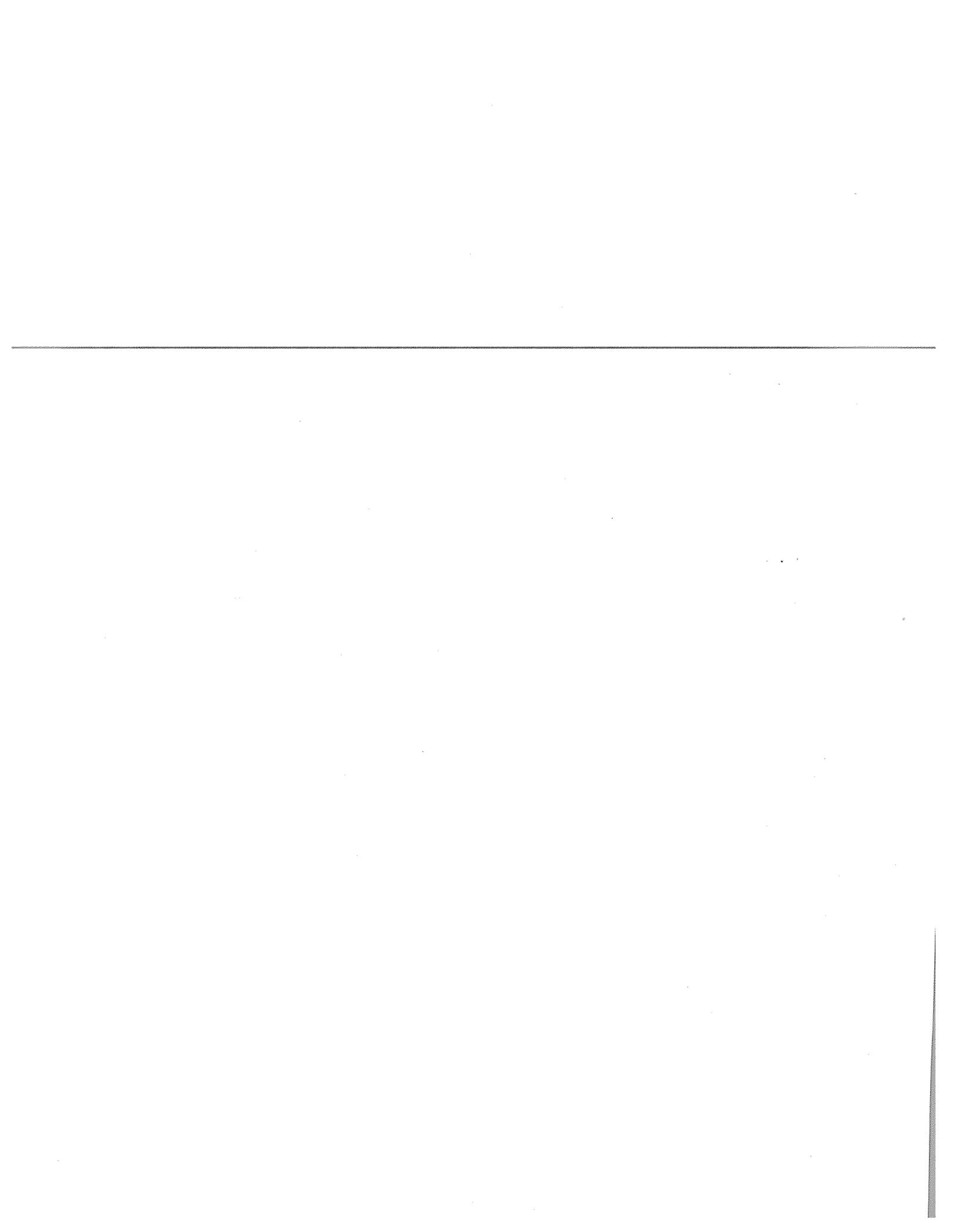
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EXISTING TAX INCENTIVES FOR HEALTH INSURANCE

The treatment of health insurance and health care expenses in the Internal Revenue Code (IRC) is the primary means by which the federal government encourages health insurance coverage. For most working Americans and their families, tax treatment of health expenses depends largely on whether their health plan is paid for by an employer, whether they are self-employed, and whether they itemize deductions and have medical expenses that exceed 7.5 percent of their adjusted gross income (AGI)¹ This brief describes federal tax incentives for health insurance, and their combined implications for costs and coverage.

EMPLOYER-SPONSORED INSURANCE (ESI)

The federal tax code most favors those with an ESI plan: the employer's contribution to the employees' and their dependents' health coverage is not treated as income. This means that it is excluded from income for *both* employee income and employer payroll tax purposes,¹ including employer and employee Social Security and Medicare taxes.*² In addition, the costs are deductible as business expenses for the employer.³ Thus, employer-provided health care is paid for with before-tax dollars.

Large employers pay, on average, about 80 percent of the cost for ESI.⁴ Unlike employer contributions, most *employee* contributions towards premiums are not excluded from taxable income and are not deductible. In other words, employees' contributions come from after-tax dollars. However, Section 125 of the IRC, and to a lesser extent, the itemized medical expense deduction (see Itemized Deduction for Medical Expenses, p.3), provides ways for employees to enjoy tax advantages on their contributions to health insurance.

Section 125 Plans

Section 125 of the IRC permits employers to offer employees two tax-favored options for benefits that the employer does not purchase: Cafeteria Plans and Flexible Spending Accounts (FSAs).[†]

Cafeteria Plans

Cafeteria plans allow employees to choose between taxable cash wages and one or more nontaxable fringe benefits for part of their compensation.⁵ Health insurance, dental care, assistance with child care, and term life insurance are examples of nontaxable benefits to which employees may apply a portion of their pre-tax wages.^{1,6} Funds that pay for health insurance premiums within a cafeteria plan are treated like the employer's contribution to

* Under the Federal Insurance Contributions Act (FICA), the employee and employer *each* pay a percentage of an employee's wages into Social Security and Medicare. The Social Security (also known as OASDI for Old Age, Survivors, and Disability Insurance) portion is 6.2 percent, and the Medicare Part A (also known as HI for Hospital Insurance) portion is 1.45 percent, for an employer and employee combined total of 15.3 percent. Self-employed people must pay *both* shares. Wages beyond a specific base are not subject to Social Security taxes; for 2007 this base is \$97,500. The HI tax, however, applies to all wages. (<http://money.cnn.com/pf/101/lessons/18/page3.html>, <http://www.ssa.gov/OACT/COLA/cbb.html#Series> accessed 1/26/2007; Brosek 2001)

[†] Although FSAs are a variant developed under IRC Section 125 rules, Section 125 only describes cafeteria plans.

ESI, *i.e.*, excluded from income and payroll taxes and deducted from the employer's business expenses.⁷

Employers also have numerous options beyond designating how much of an employee's wages are budgeted to the cafeteria plans. An employer might contribute to the health premium as a portion of their overall contribution to the cafeteria plan. The employer might fund a basic level of health coverage, and the cafeteria plan offers the employee the choice between enhancements to that basic health coverage, other benefits, or cash. Under a cafeteria plan, the employer may also require every employee to take the basic health coverage.⁶ If the employer also reimburses medical expenses through the cafeteria plan, these funds are also excluded from gross income and wages. There is no statutory limit on how much may be excluded from taxation,¹ but the employer may designate a fixed budget to be distributed among different benefits. If the employee selects options that cost more than the budgeted amount, he/she pays the difference with after-tax wages or an FSA, if available.⁶

Flexible Spending Accounts (FSAs)

FSAs are the second type of Section 125 option. Under an FSA, an employee may designate a sum to be deducted from his/her wages and deposited into an FSA (although the amount might be limited by the employer⁸). This is not taxable as income or wages,^{6,5} subject to the cafeteria plan rules.¹ If the employee establishes a health FSA, he/she may draw on his/her health FSA to pay for health premiums, coinsurance, deductibles, or medical services that are not covered by the health insurance plan, e.g., dental care or eyeglasses.^{6,3,5,1} One type of FSA, a premium conversion or premium only plan, may be used only to pay for the employee's share of health premiums. FSAs may also be available for other types of expenses, such as dependent care. Some employers allow each employee to establish more than one FSA.⁶ An FSA may exist within a cafeteria plan, or stand alone.⁸

There are two key differences between cafeteria plans and FSAs: first, the employee (not employer) determines how much money to put into the FSA (within employer-set limits), second, FSA funds that are not spent within two and one-half months of the end of the year are forfeited by the employee to the employer ("use it or lose it").^{1,6,5} With a cafeteria plan, the budgeted money that is not spent on benefits is paid to the employee as taxable wages.⁶

Section 105

Another way for employers to sponsor health insurance is to reimburse employees for medical expenses, including non-prescription drugs,[‡] with pre-tax dollars through medical reimbursement plans under IRC Section 105(b).¹ The most common example of a medical reimbursement plan is a self-funded health plan, where an employer pays for health benefits without purchasing insurance.⁹ Like the employer's share of ESI premiums, these reimbursement funds are excluded from payroll and income taxes, and the amount is not limited.¹ Health Reimbursement Accounts/Arrangements (HRAs) (see Health Reimbursement Accounts/Arrangements, p.4) and FSAs may be used as vehicles for this subsidy.

[‡] Revenue Ruling 2003-102.

DEDUCTION FOR SELF-EMPLOYED INDIVIDUALS

Since 2003, self-employed individuals have been allowed to deduct 100 percent of the cost of their health insurance and that of their spouse and dependents, but only in months when they are not eligible to participate in an employer-sponsored health plan (including their spouse's). The deduction may not exceed self-employment income and applies to the cost of health insurance only—not out-of-pocket expenses. The deduction does not affect liability for self-employment taxes, *i.e.*, Social Security and Medicare tax. This is an "above the line" deduction, meaning that it can be deducted from taxable income even if the taxpayer takes the standard deduction, rather than itemizing.^{3,5}

ITEMIZED DEDUCTION FOR MEDICAL EXPENSES

People who buy their own insurance directly, even through provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA), cannot deduct the cost, except to the extent that their premiums and other medical expenses exceed 7.5 percent of AGI.⁵ Most unreimbursed medical and dental expenses that *exceed* 7.5 percent of AGI may be itemized.⁸ Health insurance premiums are included among these deductible expenses.¹ Because this deduction is only available to taxpayers who itemize deductions, it is only helpful to taxpayers whose combined deductions exceed the standard deduction. People who have lower incomes are less likely to have enough deductions to exceed the standard deduction, but if they do, they are more likely to meet the 7.5 percent minimum.³

HEALTH COVERAGE TAX CREDIT (HCTC)

Under the Trade Act of 2002, a HCTC is available to subsidize health coverage for early retirees and workers (primarily in manufacturing) displaced by international trade. The HCTC pays 65 percent of premiums for qualified health coverage, which is primarily COBRA plans sponsored by former employers or private insurance offered through arrangements with states.¹⁰ The credit is available in advance and is refundable (available to those who have no tax liability⁵). Those entitled to other health programs are not eligible for the HCTC.^{1,10} The HCTC is a relatively small program: the Office of Management and Budget estimated that the credits totaled about \$120 million in 2004. Dorn estimated that in September of 2004, about 25,500 U.S. households might have been utilizing the HCTC.¹⁰

MEDICAL SAVINGS ACCOUNTS (MSAs)

In 1996, Health Insurance Portability and Accountability Act (HIPAA) established a pilot project to create MSAs (later known as Archer MSAs), which are personal savings accounts for unreimbursed medical expenses. MSAs were available to people who were self-employed or working in firms with fewer than 50 employees.^{5,7} Qualifying individuals were allowed to purchase inexpensive, high-deductible health plans (HDHP) and deposit up to 65 percent (75 percent for families) of the annual deductible into an MSA tax-free.⁵ For the

⁸ For itemized deductions, qualified medical care includes: 1) money paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or costs of treatment affecting any structure or function of the body, including dental expenses, prescription drugs, and insulin; 2) transportation for care; 3) qualified long-term care services; or 4) insurance covering medical care or limited amounts for long-term care premiums for a qualified contract. Generally beneficial expenses do not qualify, nor do most cosmetic surgery and procedures. (Department of the Treasury 2006) (Joint Committee on Taxation 2006).

purpose of MSAs, HDHP was defined as a plan with a deductible between \$1,800-2,700, or \$3,650-5,450 for family coverage, with out-of-pocket expenses not to exceed \$2,650 for an individual or \$6,650 for a family. Participants were permitted to use MSAs for non-qualifying expenses, but the penalty tax was 15 percent. MSAs never gained popularity, and after 2005 no new MSAs could be opened.¹

HEALTH SAVINGS ACCOUNTS (HSAs)

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 created HSAs. HSAs are more broadly available than MSAs were, and more tax-favored than other plans or arrangements. When combined with a qualifying HDHP, HSA contributions from the consumer are tax-deductible above the line, and employer contributions (including salary reduction contributions made through a cafeteria plan) are not subject to employee income taxes or payroll taxes. A qualifying HDHP must have a deductible of at least \$1,050 for an individual or \$2,100 for a family. Cost sharing may not exceed \$5,250 out of pocket per individual or \$10,500 for a family for health care services within the plan's network. Contributions to HSAs are limited to the lower of 100 percent of the deductible of the health insurance plan, or \$2,700 (\$5,450 for families) in 2006. For those age 55 or older, annual contribution limits were \$700 higher in 2006, increasing incrementally to \$1,000 in 2009.¹

HSAs may be invested in stocks, bonds or other investment vehicles.¹¹ Earnings accrued on these accounts are also not taxed, and withdrawals are tax-exempt if spent on out-of-pocket medical costs. HSA funds not spent in one year roll over.^{1,12,13} Distributions can be spent for costs other than health care, but are then included in gross income and subject to an additional 10 percent tax. If spent on qualified medical expenses, distributions are not taxed as income.¹

HEALTH REIMBURSEMENT ACCOUNTS/ARRANGEMENTS (HRAs)

Under HRAs, employers provide a fixed amount of money that an employee may use to pay medical expenses or premiums.³ HRAs are owned by *employers* to reimburse employees' qualified medical expenses; they are not funded through salary reductions.^{1,3} Employer contributions to HRAs are not treated as part of the employees' gross income, so the contributions are not treated as wages. Thus, employers pay no payroll taxes and employees pay no income taxes for these funds. Unlike HSAs, HRAs need *not* be coupled with high-deductible plans in order to qualify for tax advantages. There are no limits on how much employers contribute to these plans, and funds roll over. When an employee leaves or retires, unused funds remain with the employer.¹⁴ HRA funds may be spent only on health care.¹⁵

IMPLICATIONS OF FEDERAL TAX INCENTIVES FOR HEALTH INSURANCE

INCREASED HEALTH COVERAGE

Federal tax subsidies have helped extend health coverage to more people and increased the number of insured in several ways. First, they encourage employees to prefer health coverage to taxable income for health insurance. Second, tax subsidies encourage employers to offer health insurance as part of employee compensation.^{1,7} Third, by encouraging employer-sponsored insurance, tax subsidies promote employment-based/risk pooling, and consequently group rates and more affordable coverage.^{1,7}

Employment is an effective way of pooling risk because people generally do not choose employment based on their expected use of health care.⁷ If only those who needed (or expected to need) health care purchased health insurance, it would be even more expensive. Selden and Gray suggest that employment-based risk pooling has been a means of cost containment in a time of rapidly rising health care costs.² Another benefit of this risk pooling is that employer-sponsored insurance (ESI) usually provides insurance beyond the current year, shielding enrollees from the risk of losing coverage or having their premiums become prohibitively expensive if they become sick, or as they get older.⁵

PREDOMINANCE OF EMPLOYER-SPONSORED INSURANCE

The significant tax incentives for ESI, and the ease of administering ESI, have resulted in the predominance of ESI as a means for health coverage in the U.S. In 2003, ESI covered about 65 percent of workers and their families.¹⁶ Selden and Gray report that among people with private coverage, about 94 percent had ESI through their employer or a family member's employer in 2003.²

LOST REVENUES

The Department of Treasury estimates that just the federal income tax component of the health insurance subsidy is the highest tax expenditure, and costs over 50 percent more than the federal income tax expenditure on mortgage interest.² The various tax preferences combined were projected to cost the Treasury \$630 billion in FY 2003 through FY 2007. Most of this — 92 percent or \$581 billion — comes from the exclusion of ESI from payroll and income taxes, and much smaller sums come from the medical expense deduction (\$31 billion) and the self-employment deduction (\$8 billion).³ More recently, Burman estimated that federal tax subsidies for health insurance and health care will reduce federal tax revenues by over \$200 billion in FY 2007.¹⁷

To the extent that state taxes are based on income as calculated under the IRC, states also lose revenue through these incentives. California's tax code generally conforms to the IRC,¹⁸ so California's lost revenues are substantial. The California Department of Finance estimates that health plan-related tax expenditures exceed \$4.3 billion for fiscal year 2006-07. This

figure does not include an expenditure of \$1.2 billion for cafeteria plans, because the health care portion of this expenditure was not disaggregated from other cafeteria plan options.^{19**}

UNINTENDED CONSEQUENCES

One consequence of the generally beneficial employment-based risk pooling is “job lock”, wherein workers stay with jobs for fear of “an undesirable change in health care coverage.”¹ ESI might also have led to job lock in a more structural way: numerous analysts postulate that tax subsidies for ESI might have stifled or precluded the development of long-term contracts in the non-group market by tying health insurance to jobs, rather than people.^{5,17,21}

~~Tax subsidies for health insurance also encourage more comprehensive coverage because premiums are subsidized, while out-of-pocket costs are generally not subsidized.~~ Comprehensive coverage and the concomitant reduction in cost sharing have some important benefits. Specifically, comprehensive coverage with minimal cost sharing probably leads to better preventive care and possibly long-run savings for certain medical conditions. They also reduce consumers’ exposure to financial risk. However, comprehensive coverage may also be seen as excessive coverage, resulting in excessive consumption of medical services because consumers do not pay the full cost of their care.^{2,7,1} In turn, excessive consumption through private insurance drives insurance costs up.^{1,22}

INEQUITY

A very important problem with the current federal tax incentives for health insurance is that the incentives are seen as unfair on several levels. Some observers point out that the current tax subsidies are “upside-down,” in that the value of a tax exclusion increases with income, but is worth little to nothing to those with low incomes, who most need the subsidy to purchase insurance.^{16,5}

The following figures come from analyses of 1998 data. Subsequent changes in the tax code, beginning in 2001, decreased income tax rates for most tax brackets and consequently decreased subsidies slightly.^{5,23} However, the relative effect of the tax subsidies is qualitatively comparable.⁵

- If one considers the employer’s share of the insurance premium as part of workers’ wages, workers who earned less than \$10,000 in 1998 received ESI tax subsidies (including both payroll and income taxes) that were worth about four percent of their income and about nine percent of their health insurance premiums. The resulting premiums represented about 37 percent of their after-tax income.⁵
- For those who earned more than \$200,000, the average after-tax cost of insurance premiums was about two percent of after-tax income. The subsidy for this tax bracket amounted to 33 percent of insurance premiums and about one percent of their after-tax income.⁵

** California is not in conformity with the Internal Revenue Code with regard to HSAs, so HSAs have not yet become a California income tax expenditure. Legislation to bring California into conformity on treatment of HSAs has been proposed. (Senate Bill 25, Maldonado, 2007)

- ESI purchased by higher income families is not the same as that purchased by those in lower tax brackets. On average, families in the top tax bracket received ESI that was worth more than three times that of families in the lowest tax bracket, but it only cost them 2.3 times as much.^{16,5}
 - Similarly, this vertical inequity exists for the self-employed who do not have access to ESI: self-employed families with incomes under \$30,000 received a subsidy up to 20 percent of the insurance premium, while the subsidy for those earning over \$200,000 was up to 38 percent.⁵
-
- Obviously, the ESI subsidy most benefits those with high incomes, but not just in the size of their subsidy due to their high marginal tax rates. High-income earners are also more likely to have ESI, and lower-income earners who do get ESI tend to get less coverage, and their employers tend to pay a smaller share of their premiums (recall that the subsidy generally depends on the employer's share of the premium). Even if employers offer ESI to full-time low wage earners, low wage earners are less likely to benefit because they are more likely to work part-time or part-year.⁵

Federal tax subsidies also result in horizontal inequity, that is, different treatment among people of the same income levels. People who work for employers that do not offer ESI and who must therefore purchase insurance in the individual market receive no tax subsidies unless their costs exceed 7.5 percent of adjusted gross income. The tax-disadvantaged status for those without ESI, combined with the higher costs in the non-group market, may increase the number of uninsured.⁵

Tax subsidies also favor large firms and their workers because they have larger risk pools and bargaining power. Small firms are unable to pool risks as well as larger firms, and face higher "load costs" (overhead, including underwriting and marketing),³ leading to higher premiums. Small firms that offer ESI are likely to pay more for their policies, decreasing profits and placing them at a competitive disadvantage. Consequently, small firms are less likely than large firms to offer ESI, regardless of wages. People who do rely on group insurance through small businesses also face higher risk of losing their ESI because small businesses are more likely to fail.⁵

Self-employed workers who purchase health insurance in the non-group market have been able to deduct 100 percent of the cost of health insurance from their taxes since 2003. However, they are still disadvantaged in comparison to those with ESI, because insurance policies in the individual market are more expensive than comparable policies in the group market. Reasons for this include adverse selection among those who seek insurance and load costs (load costs in the non-group market can be 30-40 percent of the premium, compared with 10 percent or less for large groups). Furthermore, individuals cannot fully insure against the risk of getting sick beyond the current year because non-group insurance does not protect against premium increases due to future declines in health.

Gruber and Levitt calculated that about 16 percent of the U.S. nonelderly population is ineligible for a tax subsidy for health insurance at some point.²⁴ The incentives for ESI result in a severe disadvantage for those who do not have access to tax-favored health coverage, especially ESI. Burman and colleagues argue that the tax subsidies for ESI undermine one of the key purposes of subsidizing ESI, that of stemming age-based adverse selection within the employer group by encouraging the young and healthy to participate in employer groups or to work for employers who offer ESI. This objective is undermined because young workers earn less and are therefore less motivated by the tax incentive. Moreover, they are more likely to be able to get low rates in the non-group market.⁵

USING TAX INCENTIVES TO EXPAND HEALTH COVERAGE

Objectives and Considerations for Tax Incentives

Given how much tax incentives have shaped how Americans get health coverage, it is reasonable to look to changing them in order to expand coverage. Some researchers have suggested that incremental tax reforms aimed at expanding coverage should:

- encourage low-income families to participate in health insurance
- not undermine small businesses that want to offer health insurance
- encourage creation of health insurance that protects against premium increases due to unexpected declines in health
- reduce the high loads facing individuals who purchase health insurance
- encourage purchase of efficient health insurance coverage
- retain or enhance the relative advantage of ESI, not undermine it.⁵

Considerations for designing tax incentives to expand health coverage include:

- How price-sensitive are people? How large a subsidy would cause people to switch from ESI to a cheaper, more minimal non-group plan?
- What is affordable to a low-income family?
- Who is the target population for the incentive? Should a policy be highly focused, or should it be applied broadly?
- What form would the incentive take? Deductions and exclusions are more valuable to people with high tax liabilities but are limited in their ability to reach the uninsured. Of the half of the uninsured who do pay taxes, 90 percent are in the 15 percent tax bracket, so a deduction is of little value.²⁴ A credit is preferable for reaching the uninsured.
- Will the tax incentive reach low-income earners? To do so, the incentive should not only be a credit, but also refundable.^{††} To illustrate: if a \$1,000 nonrefundable credit is offered, the 60 percent of the uninsured who have tax liabilities of less than \$1,000 could not benefit from the full value of the credit. Thus tax incentives must be refundable in order to reach the low-income uninsured.²⁴ Unfortunately, refundability has the political disadvantages of administrative complexity and making subsidies look like welfare.

^{††} “Refundable” means that the full value of the credit is payable as a tax refund even if the taxpayer owes little or no income tax. (Burman LE, 2003)

- Does the subsidy address liquidity restraints (the mismatch between the usual flow of tax subsidies in the spring and the need to make insurance premium payments in advance)?²⁴

Examples of Potential Reforms

Subsidize Health Insurance Purchases in the Non-group Market

Because those who purchase health insurance in the non-group market are so disadvantaged compared to those with ESI, some propose to subsidize non-group insurance. If the subsidy is available to those without an ESI option and people are sensitive to price, some will choose to purchase cheaper, less comprehensive policies in the non-group market and receive higher wages. To the extent that healthier workers do this, ESI risk pools would experience adverse selection. It is widely held that preferences for higher wages and non-group policies would mean a decline in the relative value of ESI as a fringe benefit, resulting in employers dropping or decreasing health benefits.

A non-group insurance subsidy would need to be substantial to bring in the low-income uninsured, but the larger the subsidy, the more likely it is to lead to employers dropping employee-sponsored insurance (ESI) because of its diminished relative value. Loss of ESI could be extremely harmful to older and less healthy workers, who would face prohibitively high premiums in the non-group market.⁵ On the other hand, staff of the Joint Committee on Taxation and others note that if employment-based groups are eroded, then other group markets, such as risk pools and purchasing cooperatives, *might* develop.¹

If, however, people are *not* sensitive to the price of health insurance, new non-group tax subsidies might produce windfalls to those who already have non-group insurance, without increasing coverage much (although it would address some of the inequity in the current structure).⁵ At the same time, such subsidies would decrease government tax revenues.

Limiting eligibility of a non-group subsidy to lower income workers will decrease the likelihood of employers dropping coverage, because the higher income earners will continue to prefer the ESI. (Higher income earners are thought to be more influential in their employers' decisions about health coverage.)⁵

Expand Deductibility

Cogan, Hubbard, and Kessler argue for making all health care expenses—health insurance and out-of-pocket alike—deductible above the line for all consumers who purchase health insurance. They assert that this would decrease the price of health services relative to other goods and services, and therefore increase health care spending. In turn, increased health care use and spending would increase the price of health insurance relative to out-of-pocket expenses, which would encourage the purchase of lower-cost, higher deductible policies. Cogan and colleagues believe these high deductible policies would lower health care spending. (Experience with high-deductible health plans, though limited, does not support the assertion that adopting such plans results in substantial decreases in spending) Cogan and colleagues further argue that the deductibility of health insurance and out-of-pocket expenses

for those with insurance would be a powerful incentive to purchase health insurance. Their proposal would not change the deductibility of ESI from payroll taxes, thereby maintaining some incentive to prefer ESI.²²

Recognizing that this proposal does not help low-income earners who have no income tax liability, Cogan and colleagues propose a refundable tax credit to subsidize 25 percent of health care expenses, up to a maximum credit of \$500 for an individual or \$1,000 for a family. Both insurance and out-of-pocket expenses (conditional on having insurance) would qualify for the credit.²² Some argue that such a credit would also need to be available in advance^{1,10,25} and assignable directly to the insurer.²¹ Regardless, the credit that Cogan and colleagues propose is likely too modest to actually make insurance policies in the non-group market affordable to low income earners.

Tax Credit for Low-Income Purchasers

Another potential tax-based reform is to offer a tax credit for purchasing any qualifying health insurance, but only for very low-income individuals and families. The credit would phase out gradually with income (credits that phase out quickly create implicit taxes that could discourage work, especially among second earners).^{5,3} This would interfere least with ESI, and not cost as much as a credit available to all income levels. However, the income limit requires an assumption about the income level at which health insurance is affordable.³

Unlimited Credit for Any Health Coverage

Gruber and Levitt ran microsimulation models of five different potential subsidies, including an unlimited credit for any coverage. Their models suggest that expanding a refundable credit to apply to all health insurance spending was the least efficient of the options they considered, but it could dramatically expand coverage. Due to its broad reach, this subsidy would be very expensive. The authors observe that very large credits can substantially decrease the uninsured population, but at a very steep cost per newly insured person. They conclude that tax policy alone will probably not be a solution to the problem of uninsurance, but might be useful as one part of an overall strategy.²⁴

Burman and Gruber admit that working with the tax system may not be the most efficient way to expand health coverage, but they note that tax subsidies appear the “only game in town for increasing the federal role in providing health insurance.”¹⁶ However, some argue that a spending program, such as an expansion of the State Children’s Health Insurance Program (SCHIP), might be more effective than more tax incentives.⁵

CONCLUSION

In summary, the current tax structure heavily favors higher-income earners and people enrolled in ESI, particularly at larger firms. As a result, most working-age Americans get their insurance through their employers, and many low-income working people cannot afford health insurance. Because of risk pooling, people with ESI enjoy lower premiums and long-term coverage. The tax subsidy for ESI also encourages more comprehensive policies and probably better access to preventive care, but also possibly excessive utilization. People whose only access to health insurance is the non-group market are strongly disadvantaged, especially if their earnings are low and as they become older and/or experience health problems.

Efforts at incremental reform face significant challenges in improving the existing incentives without losing the benefits of ESI. Researchers seem to agree that new tax incentives could expand coverage modestly. Tax policy is probably best seen as part of an overall strategy to address problems with health care, rather than as a solution.

ENDNOTES

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