Reform #3: Instill Appropriate Incentives with Rational Tax Treatment of Health Spending

Principal Features of Reform #3: Instill Appropriate Incentives with Rational Tax Treatment of Health Spending

- Make tax treatment of health expenses universal, that is, equal for all, whether individual, self-employed, or employer-based
- Allow income tax and payroll tax exclusions for only two categories of expenses:
  - Limited-mandate catastrophic insurance premiums
  - HSA contributions for those with catastrophic insurance coverage
- Base income exclusion on new maximum HSA contribution (equivalent to the total annual out-of-pocket maximum, which approximately matches the 50th percentile of current employer health benefits)
- Index income exclusion increases to the Consumer Price Index for All Urban Consumers (CPI-U)

The income tax subsidy for unlimited health spending is one of the great mistakes of modern US tax policy. It creates harmful incentives for consumers that are counterproductive to competition and pricing, it replaces higher wages, and it is regressive, preferentially giving high-income earners more tax breaks.

Tax preferences for health care spending began as a somewhat unintended tax policy, as they arose from the fact that pension and

health insurance fringe benefits provided by employers were not subject to wage controls imposed during World War II to maintain war production.[1] Later, employer payments for health benefits became deductible to employers and tax excluded to employees in the Internal Revenue Service tax code.[2] The current tax code sets no limits on this income exclusion, contrary to the original intent of Congress in 1954.[3]

The largest tax subsidy for private health insurance—the exclusion from income and payroll taxes of employer and employee contributions for employer-sponsored insurance—costs approximately $250 billion in lost federal tax revenue in 2013.[4] In addition, the federal tax deduction for health expenses (including premiums) exceeding 10 percent of the adjusted gross income is estimated to cost $12.4 billion in lost tax revenue in 2014.[5] The CBO projects that tax expenditure for employment-based insurance (including income and payroll taxes) will remain close to 1.5 percent of GDP during the coming decade.[6] The tax subsidy is highly preferential to individuals with higher incomes, that is, it is highly regressive. About 85 percent of the subsidy goes to individuals in the top one-half of the income distribution.[7] In addition, the tax exclusion distorts the labor market by limiting job mobility and strongly influencing retirement decisions.[8] Still, certain positives come from employer-sponsored insurance, such as risk pooling as well as the employees' opportunity to select insurance for more than one year at a time.

Beyond the numbers, the current tax exclusion creates perverse incentives. Indeed, the observation that "the tax subsidy is responsible for much of what is widely perceived as a health care crisis" may sound like it was written only recently, yet this statement dates back almost forty years.[9] The exclusion makes health spending seem less expensive than it is. The incentive to allocate more money for health care encourages more expensive insurance policies with more elaborate coverage as well as a higher demand for medical care regardless of cost. The current tax exclusion is preferential to insurance over out-of-pocket spending (as opposed to the incen-

tive of HSAs, particularly as structured in this reform proposal). The distortion of health insurance to its now-dominant form that covers almost all billable services, including minor, fully predictable medical care, while minimizing direct payment by patients, is partly attributable to the tax preference. This preference has greatly increased the overall cost of health care.[10]

Changing the tax treatment of health spending is an important part of urgently needed health care reforms; unfortunately, comprehensive tax reform that would result in a broad-based, low-rate, simple system seems unlikely at this time. Removing the existing tax exclusion entirely would be problematic.[11] Serious repercussions could include a significant increase in the number of uninsured, an abrupt disruption of the labor market, and a dramatic increase in taxes.

Given those realities, the tax reform proposed herein eliminates the Obamacare excise tax and incorporates three main features: (1) universality regardless of the source of health benefits; (2) limits on the total allowed exclusion, and (3) new criteria on eligible spending for tax exclusion, limited only to HSA contributions and premium payments for LMCC. These tax reforms would reduce expenditures and encourage value-based insurance purchasing, that is, they would realign incentives in health insurance and health care markets to benefit consumers. Once the reforms are enacted, the increase in the individual's purchasing power for medical care more than compensates for the loss of certain tax subsidies for health care spending. Each reform is discussed in more detail below.

Universality

The current system is unfair and preferentially benefits higher-income earners who receive health benefits from employers. Current law permits families without employer-based health insurance to deduct medical expenses only if they itemize their deductions, a strategy chosen far more frequently by upper-income earners;

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moreover, the deduction is limited to expenses that exceed 10 percent of adjusted gross income. To level the playing field, I propose that all citizens be allowed the same deductibility of health expenses if they purchase the basic LMCC. The proposed income exclusion for health spending will be applicable to all, regardless of employment or source of health benefits.

Total Allowable Exclusion Limit

The proposed allowable exclusion from income and payroll taxes is based on the maximum allowable HSA contribution ($6,850), roughly equal to the 50th percentile of current health benefits paid through employment.[12] For 2014, the estimated annual health insurance premium paid per worker equaled $6,025 for individual coverage; the average premium paid for high-deductible coverage equaled $5,280. Still, the term "high deductible" was defined as plans with annual deductibles only greater than or equal to $1,250 for an individual ($2,500 for a family); it also included coverage bloated by all of the ACA mandates and regulations. In the final year before ACA regulations, 2009, the average premium of high-deductible plans equaled 82.6 percent of the average cost of employer-provided health insurance, based on annual surveys of employer health benefits. Therefore, given other reforms in this six-point proposal that would further reduce the cost of true high-deductible coverage, the new exclusion should cover the entire cost of high-deductible plans plus significant deposits to HSAs.

The CBO and the JCT estimate that setting income exclusion limits on the basis of the 50th percentile for health insurance benefits paid by or through employers in 2015 (and indexed in subsequent years for inflation using the CPI-U), with the same limits for the deduction for health insurance available to self-employed people, would reduce deficits by $537 billion over the next decade.[13] This cap would have far greater impact on upper-income earners.[14] (Note, for contrast, that the Urban Institute estimated that capping the exclusion at the 75th percentile of total health benefit through

employment would produce $264 billion in new income and payroll tax revenues over the coming decade.[15])

Eligible Spending for Income Exclusion

Current health spending eligible for tax exclusion is both unlimited in size (until the 2018 Obamacare "Cadillac tax" implementation [see the following paragraph for more on this tax]) and essentially unlimited in scope of eligible expenses. My proposal would add incentives for purchasing basic catastrophic coverage, beyond limiting the amount of the income exclusion and in addition to other incentives already described. Excludable health spending will apply only to two health expenses: (1) deposits to HSAs; and (2) premium payments for high-deductible, limited-mandate catastrophic coverage. It would be counterproductive to encourage the purchase of insurance bloated with expensive coverage requirements that minimize copays and effectively eliminate concern about prices of care. Added insurance coverage, including expensive "comprehensive" coverage, will always be available to those who wish to purchase it.

Note that my plan replaces the changes to the current tax exclusion under Obamacare set to begin in 2018. Under Obamacare, a new excise tax is set to be imposed on employment-based health benefits whose total value—including employers' and employees' tax-excluded contributions for insurance premiums and contributions made through health reimbursement accounts, flexible spending accounts, or HSAs for other health care costs—is greater than specified thresholds (subsequently to be indexed to the growth of the CPI-U). The JCT and the CBO project that those thresholds will be $10,200 for single coverage and $27,500 for family coverage in 2018. The excise tax (known as the "Cadillac tax") will equal 40 percent of the difference between the total value of tax-excluded contributions and the threshold. But designing a policy whereby a government imposes new taxes on products whose prices became unnecessarily high directly because of the government's

policies is not only bad for consumers but frankly absurd. Moreover, the Cadillac tax is set to include contributions that employers and individuals make to HSAs toward the thresholds for invoking the 40 percent excise tax. This is a classic example of a misguided government intervention harming an excellent consumer-oriented program (HSAs and high-deductible plans), ironically penalizing individuals trying to lower their health expenses.