A Sensible First Step toward Health-Care Reform

In its FY 2008 budget, the administration proposes to repeal the current open-ended tax exclusion for employer-paid health benefits and to replace it with a new capped standard deduction that would be available to all individuals and families who purchase a qualifying health plan, whether on their own or through their employer.

This is an eminently sensible reform. Health-care experts have long recognized that the current open-ended employer exclusion is needlessly costly, encourages Americans to overconsume health care, and heaps the biggest subsidies on those who need them least while doing nothing to help the 46 million Americans who lack any insurance at all. According to the CBO, the reform would generate large budget savings, reduce the number of uninsured, and, over the long run, could help moderate the growth in health-care costs.

Many critics are faulting the administration's plan for not doing more to extend health coverage. The critics are right that the reform does not alone add up to comprehensive reform. Guaranteeing that all Americans have access to affordable health insurance will require a lot more than this—probably some combination of new government mandates, subsides, and insurance market reforms. But the critics are wrong that this is an argument against the reform.

The bottom line is whether America would be better off with the reform than without it—and here the answer is unambiguous. Reforming the tax exclusion is the single most important step that Congress can take to improve the efficiency and equity of our dysfunctional health system. Moreover, it is a step that it will need to take whatever shape comprehensive reform ultimately assumes.

A Costly and Perverse Subsidy

It's worth recalling that the current open-ended exclusion for employer-paid health benefits is the result of historical accident rather than deliberate policy. When the federal government imposed a wage freeze during World War II, businesses began to offer health benefits to employees as a way of increasing compensation. In the late 1940s, the government issued an ad hoc ruling that employer-paid health benefits, as well as other fringes, should not be subject to federal income or payroll taxes. No one gave much thought to it at the time, since tax rates for most workers were low and fringes, including health care, were tiny.

That ruling turned out to be costly beyond the wildest imaginings of anyone at the time. According to the Joint Committee on Taxation (JTC), the exclusion for employer-paid health benefits will directly cost the federal government $99.7 billion in lost income tax revenue in FY 2007, considerably more than the better-known home mortgage interest deduction. Including foregone payroll tax revenue, the total tax loss will come to at least $150 billion.

This subsidy is not only costly to the federal budget. Health-care experts agree that the tax exclusion for employer-paid health benefits is one of the main reasons Americans spend so much on health care. It encourages employees to "purchase" more generous coverage than they otherwise would, channeling resources toward health-care consumption and away from other priorities. Moreover, it gives the same preferential tax treatment to the last dollar spent on health care as to the first, and thus subsidizes not just basic coverage, but "gold-plated" health benefit plans.

The tax exclusion adds to the deficit and drives up health-care costs. But this doesn't exhaust the list of its ill effects. The exclusion is also a steeply regressive subsidy, since its value increases along with the marginal tax rate. Perversely, it offers the greatest incentive for additional insurance coverage to those workers who are in high tax brackets and are already likely to be the best insured—while offering the least to workers in lower tax brackets who are likely to be the least well insured.

What's worse, it gives no help to the tens of millions of mostly low-wage workers whose employers do not offer health insurance at all. According to the Lewin Group, families with incomes of $100,000 or more received an average tax subsidy of $2,780 in 2004, compared with an average subsidy of $725 for families with incomes between $20,000 and $30,000 and an average subsidy of just $102 for families making less than $10,000.

ISSUE IN FOCUS by Richard Jackson

A Bold Proposal

The administration would repeal the tax exclusion for employer-paid health benefits, as well as the special tax deductions for self-employed workers who purchase health insurance and tax filers who itemize medical expenses. In their place, it would create a new standard deduction for all non-Medicare eligible Americans with qualifying health insurance. The deduction would be set at $7,500 for individuals and $15,000 for families in 2009, the year the reform would go into effect, and would thereafter be indexed to inflation.

This bold proposal has many merits. For starters, it would generate large long-term budget savings. According to the JTC, the reform would result in a small revenue loss for the first few years, both because the new deduction would initially be larger than the cost of employer insurance for most workers and because people who do not now have insurance would be encouraged to purchase it. The administration estimates that in 2009 between 75 and 80 percent of policies would have premiums below the deduction amount. Over time, however, the revenue loss would turn

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into a large and growing revenue gain, since the deduction is only indexed to inflation and so would grow more slowly than average premiums are projected to under current law. Between 2009 and 2017, according to the JTC, the reform would generate cumulative budget savings of $334 billion.

The reform would also eliminate the gross inequity in the current tax treatment of employer-paid and individually purchased insurance, and by doing so would encourage more Americans to obtain health coverage. In 2010, according to the CBO, 7 million more Americans would be insured with the reform than without it. Projections by the JTC and the Lewin Group show a similar improvement.

Most important, the reform would fundamentally change the economic incentives in the health system. In effect, the reform would tax health premiums at the margin, which would have almost as large an impact as making all premiums taxable. Unlike the current system, there would be no additional subsidy for coverage that exceeds the minimum requirement. An individual or family that spends less on insurance than the full deduction would still receive the full deduction, creating a powerful incentive to control costs. This incentive would be reinforced by greater transparency. Under the reform, workers would see the full cost of employer-paid health premiums reported on their W2s, whereas today this cost is largely invisible to them.

The reform, moreover, would not only reduce "induced" demand for health care and cause many employers to switch to lower-priced, more cost-effective plans. It would also encourage providers and insurers to compete to deliver quality care at a price lower than the standard deduction, thus applying an additional brake to cost growth.

In recent decades, the federal government's tax treatment of employer-paid health benefits has distorted household spending decisions and caused a rising share of worker compensation to flow into health-care consumption rather than wages. The reform would slow and perhaps reverse this trend. According to the CBO, the average cost of workers' insurance policies in 2010 would be an astonishing 15 percent lower with the reform than without it. The potential efficiency and welfare gains are thus enormous.

Misdirected Criticism

Despite its potential benefits, the administration's proposal is attracting criticism. Although the reform raises some legitimate policy concerns, most of the criticism is misdirected.

One charge is that the reform fails to assure universal coverage. Although this is true, it is besides the point. The relevant comparison is with current law, not an ideal and as yet unattainable goal. According to all the projections, the reform's equalization of the tax treatment of employer-paid and individually purchased health insurance would alone lead to a substantial net gain in the number of insured Americas, even ignoring the potential for slower growth in health-care costs to make insurance more affordable.

Another charge is that the reform, even if it does increase the overall number of insured, will lead to a shift from employer-paid insurance toward individually purchased insurance. The concern is that younger and healthier workers will find it in their financial interest to leave employer plans and purchase individual policies, undermining the large and stable risk pools that allow firms to cross-subsidize the health insurance of older and sicker workers.

While this concern is legitimate, it is exaggerated. Experts agree that the vast majority of medium and large firms, which now employ most workers with health coverage, would still be able to offer even young and healthy employees insurance at a lower cost than what they could obtain on their own in the nongroup market. This is because, even with tax subsides equalized, they would still enjoy a large advantage in administrative costs. The "adverse selection" problem is largely limited to workers at small firms.

For these workers, government could sponsor risk pools that duplicate the pools employers now offer. Even without risk pools, government could give special subsidies to high-risk individuals that cap insurance costs and protect against untoward outcomes. In any case, the problem of adverse selection is not unique to the administration's plan. Short of mandating employer coverage, practically any reform that tries to extend insurance to more lower-income Americans will end up eroding employer coverage at the margin, as has been the case with recent liberalizations of Medicaid and SCHIP.

A final charge is that the reform would still give a disproportionate share of tax benefits to the affluent. It is true that the new standard deduction, like the existing exclusion, would be worth more to people in higher tax brackets. The more important point, however, is that the subsidy would be much smaller than under current law. The reason that the reform generates large long-term budget savings is that it makes large cuts in benefits to higher-earning Americans.

If desired, it would be easy to redesign the reform to deliver more or even all of the tax benefits to lower earners. This could be done by converting the standard deduction into a flat refundable tax credit or a sliding-scale credit. The reform's basic approach is compatible with any degree of progressivity. The problem here is not that the reform goes too far, but that it may not go far enough.

Ideological Blinders

Virtually no health-care expert believes that it is good economic or social policy to give tax breaks to some people because they have employer-paid insurance but not to others because they don't. And virtually none believes that it is good policy to subsidize the last dollar that people spend on health care as much as we subsidize the first.

So why hasn't the administration's proposal gained broader support? In the end, it boils down to the perception that the reform will push the health system toward a particular market-driven vision of comprehensive reform—a vision that many health experts do not share.

But this perception is mistaken. Reforming today's open-ended and discriminatory subsidy would be an advisable step no matter what vision of reform America ultimately embraces. The subsidy would be counterproductive in a single-payer national health system. It would even be counterproductive in a mandatory employer system. Let's not let ideological blinders keep us from enacting a sensible reform that would cut the deficit, help control health-care costs, and reduce the number of uninsured Americans. ■