

**ADMINISTERING SOCIAL PROBLEMS THROUGH THE TAX SYSTEM: TAX IMPLICATIONS OF
HEALTH BENEFITS**

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Introduction

The current US tax system treats expenditures for medical care and medical insurance in ways that differ from the treatment of most other items of consumption expenditure. Compensation diverted to health insurance benefits for workers who obtain employment-based health insurance is excluded from federal income and payroll taxation (and from almost all state and local taxes as well), payments employees make for the premiums of group insurances they choose to take can be excluded from taxation if the firm has a cafeteria benefits plan, monies set aside from taxable wages in a flexible spending account can be excluded from federal income taxes, and payments employers sequester in a personal savings account can likewise be excluded. (In addition, expenses on medical care that exceed 7.5% of adjusted gross income are permitted as deductions on the personal income tax for those who itemize deductions, but this of negligible importance compared to the exclusion and will be ignored in what follows.)

Recent estimates suggest that the value of these exclusions (relative to the tax that would have been paid if these were ordinary consumption items paid out of taxable income and wages) exceeds \$132 billion at the federal level, with at least another \$14 billion lost to states and local governments. This “tax subsidy” amounts to about 20 percent of all private medical care spending. This subsidy is much more than the administrative cost of private insurance, and therefore means that it is more advantageous to run medical spending through insurance than to pay for it directly out of pocket, even if the expense is neither large nor uncertain.

Policymakers have in various ways both questioned the current use of these provisions and suggested adding new variations in pursuit of goals for health and health insurance policy. In this paper I will review the theoretical analysis and empirical evidence on the effects (compared to alternative benchmarks) of the current tax treatment of health insurance and medical care, focusing on but not limiting the analysis to health insurance benefits in the employment setting. I will consider within the narrow perspective of goals and challenges to health policy how the tax treatment might be changed, and I will close with some observations on integrating that tax treatment of health benefits into a more coherent approach to taxation in general. While much of what I have to say is settled fact (or at least something “most economists” agree on), there are also large differences of opinion on how current and

prospective tax treatments would affect outcomes, along with even more diversity in postulated social goals and constraints. I will try to identify as such statements which are matters of opinion, including my own.

What Makes Medical Expenditures Different?

While there are other specific types of expenditures singled out for special tax treatment, for the great bulk of consumption goods, the choices people make do not affect their federal income taxes. Medical care goods and services are different from most types of consumption expenditure in three ways. (None of these differences, I hasten to add, is absolutely exclusive to medical care, but I believe the combination is unique.) First, much medical care spending is a response to illnesses which reduce a person's health and which occur in unpredictable ways. That is, much of medical care spending can be thought of as a partial repair or response to casualty loss that affects the physical person rather than inanimate wealth. Second, and partly for the reason just specified, much of medical care spending is covered by voluntarily purchased private insurance. Third, some medical care spending affects the non-user—most obviously for treatment to prevent or cure a disease that others could catch but also, more subjectively but more importantly, because human beings seem to care about the relief of physical suffering of other humans.

As noted, not all of these distinctions are watertight: some medical care is preventive care which occurs (if the consumer chooses) with probability one. Some medical care spending, such as cosmetic surgery or human growth hormone treatments, do not remedy conditions usually (socially) defined as "illness." And not everyone cares about all their fellow human beings, and not all persons are necessarily the same objects of concern. Still, they provide some of the rationale for special tax treatment. The extensions of the first and third reasons are easy to see. Since we cannot evaluate the amount of the casualty loss that occurs (for example, when I get the flu and don't work up to par), we use what I spend on medical care as a proxy. Since my medical care use generates external benefits to others, there is a rationale for a subsidy of some type, especially if the level of use I would choose in the absence of a subsidy is a level at which marginal external benefits are high.

The availability of medical insurance (the second difference) would actually seem to weaken the casualty loss rationale. For damages to property, deductions against physical losses are permitted only for uninsured losses, and

the premium is not a deductible expense on the individual income tax. And yet by far the largest subsidy is provided to health insurance. That subsidy is directed to insurance provided in connection with employment—so-called “employer paid” insurance. Its rationale in turn is an extension of arguments made for other types of employment related benefits. There are various ways, to be detailed below, in which payments for health insurance or medical care may be shielded from taxation if made as part of compensation payments to an employee. (In recent years some of these advantages have been extended to people who are self employed, but not to those who receive capital or other “unearned” income, or to those employees who buy insurance themselves when it does not come with their job.) For the most part, the fundamental rationale for exclusion is not specific to the medical nature of these payments but is related to the exclusion of a variety of noncash forms of worker compensation, such as unemployment insurance, disability insurance, and child care.

Why Not Tax Compensation in the Form of Insurance Premiums?

To review some ancient (but still important) history: employer expenditures that benefit employees are generally excluded from taxable income if they are chosen by the employer “for the benefit of the employer.” Payment of travel expenses or employee meals first fit this category, but expenditures for employee welfare were also included during World War II. In some rough sense, the key feature which distinguishes nontaxable benefits from taxable wages appears to be the degree of individual worker versus employer control over the amounts and uses of funds. So long as at least some vestige of employer choice remains, the funds may be regarded as nontaxable income. The rationale for this exclusion is that, because the employee’s choice was limited, it may be incorrect to assume that the benefits are of value to the employee, or are of as much value as their cost. Therefore it would be incorrect to tax them as income over which the employee has full control.

The second (though by no means inconsistent) reason for favorable tax treatment of employment related benefits is that there are social interests in encouraging both the object of the benefits (effective medical care) and the use of the employment based mechanism as a means to furnish them. The primary argument for benefits as an object is to encourage medical care use by those who would otherwise not choose to use it, with the low user price associated with insurance as the tool for encouragement. The use of the employment based system is favored (in addition to

tradition) because it is felt that it spreads the premiums more uniformly over workers than would be the case if insurance or care were purchased individually; what Uwe Reinhardt has called “Corporate Socialism” appeals to many (though not to him).

There is little doubt that the favorable tax treatment of compensation received in the form of medical benefits has encouraged the choice of this form of compensation relative to money wages, though the exact historical causes and timing of growth in the benefits share is subject to some debate. What is quite unclear, however, is appropriate positive model to understand how this process works and how it might be affected by changes in policy. On the one hand, workers might perfectly sort themselves across firms based (among other things) on their health benefits offerings. Then each worker will get exactly what he or she wants (given the tax exclusion and other features); in fact, and in contrast to one of the rationales for exclusion, there will be no problem of under valuation. On the other hand, workers may choose or end up in jobs independent of the existence or value of benefits; benefits may be of high value to some but of low value to others (and rejected if they have an opportunity to take cash instead). As we will see there is some evidence in support of both of these propositions. Of course, the “encouragement” rationale only works if workers prefer jobs with better benefits.

What is even less clear than the positive or behavioral question about tax shielded health benefits is the normative question: what social goals might such tax treatment achieve, and how well will it achieve them compared to other kinds of public intervention?

In some broad sense, as already suggested, we know what the social goal is: to help people to use the medical care others think they should use. In large measure ambiguity exists because no one really knows the optimal quantity. We know that in general medical care is subject to marginal benefit that diminishes smoothly and slowly; there is no unique amount of care for a population or even for an individual that represents the amount “needed” (in the sense that a little less is very harmful and a little more is virtually useless); we could all benefit from more frequent screenings for treatable disease, or better treatment of conditions we already have, and the ability of the medical care system to devise and treat in ways which do more good than harm is virtually without limit. (This is not equivalent to saying that all current use does more good than harm; overtreatment is possible and probably exists, but it is very

hard to identify before the fact.) There is no agreed-upon set of basic medical care needs or basic insurance needs that can be agreed-upon, not because people are contentious but because what is ideal depends on things both not known and changeable, like the marginal value of health and the marginal cost of care.

Even with this little to go on, however, there are some reasons to think that the current tax exclusion may not be the best form of encouragement or subsidy. Most generally, as with all types of deductibility or exclusion, the magnitude of the incentive varies directly with the marginal tax rate, which increases with income. However, it is certain that under-use of medical care and lack of insurance is positively related to income (even in the unsubsidized individual insurance market). So the subsidy is not well targeted. It also seems obvious that beyond some point additional medical care spending, or insurance that encourages such spending, will be of minimal or no social value. However, at present most of the devices for special tax treatment of medical care and medical insurance are open-ended. (The major exception is for the tax shielded flexible spending account, where the maximum annual contribution is \$4000.) Still, it seems clear that abolishing this favorable tax treatment with nothing else replacing it will cause some people to stop obtaining insurance and/or fail to get highly beneficial medical care that would be of social value.

The Empirical Evidence: What Difference Does the Exclusion Make?

To understand the empirical research on the effects of the exclusion, it is necessary to state the conclusion of the economic model of employer-provided benefits in competitive labor markets. Under a number of different, but plausible, assumptions, the incidence of employer payments for benefits will fall on worker wages. A corollary of this conclusion is that the profit maximizing employer should choose the level and type of benefits that employees would prefer, given that the net premium for insurance is lowered by the exclusion. Perhaps the strongest evidence in support of the conclusion about evidence is that, despite some apparent heterogeneity in firm labor forces, health benefit levels are chosen as if employees were demanding them, and therefore respond to the presence and the size of the exclusion.¹

From empirical research of several decades on the tax exclusion, I think it is possible to conclude with great confidence that the exclusion does make a material difference to the aggregate level of private insurance coverage among the under-65 working population. Phelps' classic study, based on the labor economics model just described, provides benchmark point estimates; using data from the 1970s (when marginal tax rates were somewhat higher than now but health insurance premiums much lower), he concluded that the abolition of the tax exclusion (by making employer payments for health insurance taxable income) would nearly double the out of pocket share of medical spending (from the then-prevailing rate of about 25 percent up to 45 percent).² Using estimates of the responsiveness of use and expenditures from the Rand Health Insurance Experiment, he concluded that medical spending for this population would fall by 10 to 20 percent.³ More recent estimates of the impact of insurance on use suggest that the elasticity might be somewhat higher than what Phelps used, and other estimates of the impact of tax subsidies on coverage levels tend to get somewhat lower estimates than his, but those are probably the right orders of magnitude.⁴

One of the problems with direct estimation of the impact of the tax exclusion is that there is relatively little time series or cross sectional variation in marginal tax rates, given income; analysts have had to use less-than-robust sources of variation, like variation in state income tax rates or variation in individual marginal rates, given income, associated with capital gains, tax exempt securities, and the like. Moreover, it is difficult to find variation in tax rates not associated with variation in income for other reasons.

Some recent estimates follow the Phelps' approach of linking employee net premiums to final outcomes, and tend to find elasticities large enough to suggest both that the exclusion makes a difference to higher income workers and that moderate tax credits (to be discussed further below) would make an important difference for the "tweener" uninsured.

Other recent research has attempted to deal with the different problem of splitting the decision on employee coverage into two parts: what is the effect of the net price of insurance faced by employees on whether their employer offers insurance coverage (with often some positive employee premium), and what is the effect of the employee premium share in the decision to take coverage once offered?

Jon Gruber and Michael Lettau have found evidence that the decision to offer coverage responds strongly to the net premium.⁵ In contrast, the decision to take offered coverage seems, based on this work and that of others, to be relatively unresponsive to the employee's premium amount or share. However, since the takeup rate is usually greater than 90 percent regardless of the employee share, it may well be that those employees who decline coverage are atypical; having inattentively chosen to work for a firm that offers benefits at lower wages but then rejected those benefits, they may also be especially unconcerned with health insurance per se.

One important issue that is poorly understood is how firms decide on group benefits when some employees value them more than others. In the aggregate, matching is good but not perfect; we do not know how a firm could respond if tax credits were offered only to some of their employees that exceeded their tax exclusion values. How would firms weigh gains to these employees from dropping group coverage against losses to other employees now faced with paying unsubsidized individual insurance premiums? As long as the fraction of employees gaining is small and the loss from dropping group insurance to other workers large, it would seem unlikely that a firm would take the drastic step of dropping coverage. Of course, if the group is small but heterogeneous and the group insurance as poorly managed as it often is in small firms, it may be more efficient to respond to more neutral subsidies by choosing individual coverage. The firms ought to determine what to do by paying attention to the "marginal" workers—those whom it specifically wants to attract and retain. Since we do not know who these workers are, any estimates of this behavior are highly speculative.

The Tax Exclusion and Insurance Coverage

The average value per family of the employer exclusion was \$1155 in 2000 but, as Figure 1 shows, this was distributed very unevenly across families of different income levels. The value of the tax exclusion combined with the effect of income per se produces a pattern of distribution of uninsurance among income classes that is skewed toward lower incomes as shown in Table 1. The very poor receive coverage through Medicaid, so the result is that nearly half of the uninsured (47.3%) are "tweeners" with incomes between the poverty line and 300 percent of the poverty line, which is approximately median income. While the number of uninsured remains stubbornly high at

about 40 million Americans, Table 2 shows that the level of coverage of those who are insured, fueled in part by the tax exclusion, has more than kept up with the growth of medical care spending and is projected to continue to do so in the future. The percentage of natural health expenditures paid out of pocket and not covered by and “third party” dropped steeply in the mid-1990s (owing to the spread of managed care with relatively nominal copayments), and is projected to trend even lower than its current value of approximately 14 percent.

The implication then is that the tax exclusion has led to acquisition and retention of ever-more generous insurance coverage by most Americans. However, it has failed to reach a sizeable minority of the “tweener” population and, in the face of slower economic growth and rising insurance premiums, that minority is growing.

Other Features of the Tax Treatment of Employee Benefits

More recent research has focused on some other ways in which an employer can provide favorable tax treatment for employee health insurance and medical care. One method is through the use of a cafeteria plan. By setting up such a plan it is possible for employee or employer to reduce taxable money wages in order to pay for various benefits including (but not limited to) the employee premium share of any health plan offered by the employer. This tax exclusion does seem to effect the level of health insurance coverage,⁶ even though it is not selected by many employment groups.⁷ The net effect of such a provision is both to encourage additional coverage and to distort the choice among plans if the premium differences reflect cost differences. While this provision clearly removes a distortion between employer-paid and employee paid premiums, in most circumstances the full incidence of premiums is on wages regardless. What it does do is remove a disincentive for offering multiple plans and having employees pay premiums reflective of relative costs, but then it distorts the relative premium measure itself. It is hard to say whether on balance there is an efficiency improvement.

Another situation in which it is difficult to see if distortions offset has to do with the offering of catastrophic (high deductible) coverage. Suppose that high deductible coverage and low deductible but strongly managed care insurance have the same expected costs. Then the tax shield for premiums distorts choice in the direction of the managed care plan. To offset this distortion, there are several vehicles for putting the premium reduction from

catastrophic coverage into a tax shielded savings account. The best known way to do this is the Medical Savings Account; a version of it now being initiated uses employer-controlled “Personal Savings Accounts” to equalize the tax advantage. The problem is that the tax shielded spending account can only be used for medical care; this provision in effect makes the deductible less cost constraining than if money saved by being frugal on medical care could be used for anything. There are ways of incorporating MSA-type accounts into a less distortive tax treatment, but they are not currently present in the tax system.⁸

What are the effects of either of these devices? Permitting employee premiums or spending accounts to be tax free does make it likely that workers will choose more cost constraining health plans—managed care in the case of cafeteria plans, catastrophic in the case of MSA arrangements. Research suggests that either of these types of plans will reduce medical spending, probably on the order of 10 to 15 percent. However, there is little evidence that either scheme has been especially effective at getting people to choose these plans. Managed care would probably have spread without the cafeteria plan option, and so far MSA-type plans have not garnered a large market share.

Conclusion: Effects of the Tax treatment of Health Benefits

There are strong theoretical reasons to believe that the more favorable tax treatment of employer provided health insurance encourages workers to have health insurance, to have more costly insurance than they would otherwise have chosen, and to arrange that insurance through their job rather than to obtain it individually. The magnitudes of these effects are hard to estimate precisely but probably are substantial. The effect of more recent innovations in health benefits intended to neutralize some of the distortion currently seem rather small, but could eventually be larger.

The other effect of the tax exclusion and related features would seem to be a loss in federal revenue and a reduction in taxes for employees with here incomes who both get more benefit from an exclusion and tend to have more costly benefits. However, this assumes that it would be apolitical equilibrium to cancel the tax exclusion with nothing else changing, which may not be the case.⁹ However, even if removal of the distortion would be distributionally neutral,

it would seem that it could be efficiency improving—not compared to no subsidy program whatsoever, but rather compared to some alternative program. That is the topic to which I now turn.

Tax Credits for Health Insurance

Most recent discussion of the use of the tax systems to achieve social objectives in health care and health insurance has not envisioned—at least initially—major changes in the tax exclusion. Instead, the proposals involving extending similar tax treatment to people in situations which, ideally, fit around the tax exclusion. The administration’s proposal for refundable tax credits for health insurance provides an example. That proposal could offer tax credits equal to 90 percent of the insurance premium for any type of a genuine health insurance for households with incomes under 200 percent of the poverty line; the credit would then gradually phase out. This credit could be used to cover the household’s explicit premium for any insurance, whether individual or group, profit or non-profit, *except* for insurance whose premium was paid (wholly or partially) by the employer.

Some Key Features

At the income levels eligible for the credit, very few households will be paying income taxes, so the credit will primarily offset payroll taxes for Social Security and Medicare. The credit is refundable, so even if it exceeds the payroll tax liability (at an annual income of about \$8000 for the \$1000 self-only credit), the excess is provided in the same fashion on the earned income tax credit.

What would be the effect of tax credits like this one on the level of insurance coverage? Who would claim the credit, and of those how many would formerly have been uninsured? Would there be any effect on the offering or takeup of employment-based insurance?

The answer to this question depends obviously on the size and form of the tax credit. Let obviously, it depends on the specification of any qualifying policy. Let me take the last issue first. What would be the “takeup rate” of the administration’s plan? The way this question has usually been approached (by me and by others) is to calculate the

difference between the maximum credit and the premium (in the nongroup market) of a benchmark average or typical plan. For self-only coverage, the average premium (across all under-65 insured persons) is approximately \$2500. The question then is: how many more people would buy that insurance if its premium was reduced by \$1000 (or 1000/2500, or 40 percent)?

There are complexities even at this level, because premiums in the individual market vary to some extent with age (as well as with location and, to a modest extent, with pre-existing conditions). But technically this is the correct way to formulate the question only if the benchmark policy is the only that qualifies the credit.

In the case of the administration's proposal, there is no "minimum coverage" requirement on a qualified policy; the only requirement on a policy to garner the maximum credit is that its premium exceed \$1111 (since $.9 \times 1111 = 1000$). So the right way to phrase the question might be: "Compared to remaining uninsured, how many people would be willing to pay \$111 per year for an insurance that buys as much coverage as the person can get for \$1111?" Or, more informally, who would turn down an offer to buy \$1111 worth of insurance for \$111?

With suitable dissemination of information, the answer to this could be: "close to all of those eligible for this credit." To offset this good news, however, there is potential bad news: for some (though by no means all) of the eligible uninsured, \$1111 spent in the individual market will still leave a person with a relatively high level of expected medical expenses.

Using data from the largest health insurance website, we investigated (for the year 2002) the pattern of premiums for individual health insurance. Specifying the policy as a PPO with a \$1000 individual deductible, we found that (depending on the assumption make about the distribution of underwriting risk and insurance underwriting policies, from 21% to 85% of eligible insureds would face premiums less than or (given recent inflation) close to \$1000.¹⁰

Older persons, especially those who live in high medical cost areas, would pay premiums that would make their direct payment greater than approximately \$100 per year. (However, the uninsured are disproportionately young, and older people surprisingly are more willing to buy typical individual insurance (given income) than are younger

people.) Coverage would have to be substantially less generous for such persons, compared to that for younger people, to result in the \$100 net premium.

What would happen and how would we feel about it? One is tempted to say—and many critics of the administration’s proposal have said—that the amount of coverage for such a high-cost person is too little to bother with. Usually they have assumed that coverage will take the form of catastrophic insurance and concluded that the annual deductible would need to be so large—\$5,000 to \$10,000—as to be “unaffordable” for the low income persons it insured, and therefore would make the coverage irrelevant.¹¹ However, this conclusion is wrong; it results from using coverage provided insurance premiums charged to today’s insured, who are middle income and above, for the newly insured users of credits. The reason is that the expected benefits for \$1100 worth of coverage—about \$800 to \$900 at the loadings likely for subsidized individual insurance—have to be spent on something in competitive equilibrium. If almost no one covers a \$5,000 deductible, then insurance market equilibrium requires that the deductible be lowered until the expected benefits embodied in the premium are in fact paid out.

There is a deeper point here. If demand for medical care responds to income then higher income persons will make greater use of an insurance policy with a given deductible than will lower income people. If expected benefits thus vary directly with income but premiums do not, there will be adverse selection which will result in over insurance for higher income people and underinsurance or no insurance for lower income people. (This will occur even for those with relatively good health who could “afford” insurance.)

In any case, the fundamental point is that these insurance purchasers using the credits can be identified as lower income, and thus, if offered their own insurance policy, will in equilibrium be offered coverage at which enough people cover the deductible that (given insurer administrative cost) about \$900 of expected benefits per insured person are paid out. In that sense, the coverage *must* be “meaningful,” or at least as meaningful as \$900 less spent on medical care can be.

It still remains to be asked whether people eligible for these credits would choose full coverage above a deductible, compared to some other policy. As might be expected, a key determinant of the pattern of coverage is what the

person's out-of-pocket payments would be in the absence of coverage. *If* there is no charity or bad debt care, then as might be expected, optimal coverage is full coverage (that protects against losses very large relative to wealth) above a deductible. However, if low income uninsured people, even those not strictly speaking below the poverty line, can expect charity care if serious illness strikes, there will be no reason to seek to cover the deductible for what is expected to be serious illness and therefore no reason to buy coverage of expenses above the deductible. The coverage that will be best for such persons—the best coverage that \$1100 can buy—will be insurance that protects against the Medicare-sized expenses that they would be required to pay but which would substantially cut into income. Roughly speaking, as we showed some time ago, the optimal policy then turns out to be a “500-5000” policy—say, a policy with a \$500 deductible and a \$5000 upper limit. People would prefer a contract that paid nothing for illnesses that turn out to be so expensive as to make them eligible for free care, but state insurance departments would not approve such insurance cynical contracts. Recently, the *Wall Street Journal* has brought to our attention the fact that such policies exist, although they neglect our arguments about why people demand them and why they are or can be helpful.¹²

The definitional essence remains: Compared to having no insurance at all, would we want to label a middle aged person with income at 200 percent of the poverty line who has bought a 500-5000 policy (or a catastrophic policy) as “insured”? A more descriptive terminology might be “insured but incompletely insured,” but then that label applies to almost everyone with private insurance. (Only Medicaid in some states provides complete coverage.) Normative terms like “insured but under-insured” or “insured but inadequately -insured” might be preferred by some. But that begs the question we began with—how much insurance is adequate?

We can go a little beyond opinions and value judgments in answering this question. The RAND health insurance experiment of twenty years ago actually tested the differential impact on health of very generous insurance coverage relative to catastrophic insurance that capped total out of pocket payments at 5, 10, or 25% of income—and found only quite small effects on health, limited to persons at initial high risk who had high blood pressure.

Tax Credits for Health Insurance and Tax Reform

Both as a matter of esthetics and economics, the current complex and cluttered tax code is displeasing. The baroque ways in which taxes can be reduced by various deals between employer and workers, even before further elaboration in the form of MSAs, FSAs, and PSAs, cannot represent sound policy. While it is obviously politically difficult to strip away accretions which were created to satisfy powerful constituencies, at last we should try to avoid making matters worse. Here I try to contribute to this effort by discussing how this treatment of health care and health insurance might be reconciled with tax reform in general, and with the flat tax in particular.

Almost every flat tax proposal has in it a hefty front-end exclusion of income for taxation, intended to reflect the amount of money needed to buy “necessities” that we want all Americans to have, such as food, housing, and (importantly) medical care.¹³ I will assume that insurance loading is sufficiently low that the optimal way to pay for the bulk of needed medical care is through insurance. (There are a few relatively inexpensive types of preventive care that are effective.)

Another thought that may help with this problem (as with others) is to point out that tax credits *are* tax reductions: they return funds to the taxpayer that would otherwise have been compulsorily extracted from him or her. What a health insurance tax credit does is condition that return of funds on the purchase of some minimum level of insurance. For example, the administration’s tax credit proposal is a lower-middle-income tax cut for those households not currently benefiting from the employment-based exclusion. In a sense, it is a tax cut *conditional on “responsible” behavior*, but it is still a tax cut. For the tweeners, the credits of the magnitude usually discussed fall short of total taxes (income, payroll, sales), even when they exceed income taxes.

To put these two pieces together. Flat tax reform proposals exclude from taxation income that is supposed to be spent on health insurance. Tax credit proposals limit the size of that exclusion based on whether households actually do buy at least some of this necessity. We obviously walk a fine line between clarity and precision here, with only a vague sense of social objectives to point the way. But if we can agree that everyone should have some insurance, and if refundable tax credits achieve that objective, then we have a justification for such credits still consistent with a low and uniform marginal tax rate above a generous exclusion.

Practical Attempts at Getting Practical

If we can square tax credits in concept with an attractive tax philosophy, what are ways to get from here to there? Because there are a thousand details in the federal tax code, they cannot be approached piecemeal. Some priorities need to be set: which is more important, substantial reduction in fraction of the population without any insurance of any kind, versus reductions in the extent of coverage of real but moderate cost containment potential for the upper middle class? To be sure, this choice may be too stark; of the few who took up MSA type insurance plans, a disproportionately large proportion has been formerly “tweener” uninsureds. Given the relatively modest subsidy provided by the tax exclusion, these people are typically the uninsured, they would probably also be attracted by the tax credit.

However, as John Goodman and I have suggested, the ideal approach would be to have a lump-sum or near-lump-sum subsidy (like that in the Bush proposal) available to all types of health insurance that have a premium at least as large as the credit.¹⁴ Among the eligible plans would be catastrophic health plans, as in an MSA arrangement, but they would be treated the same as any other insurance option. Whether or not there needs to be special treatment of an earmarked fund could be discussed. Beyond a general intent to reduce the tax on all savings (e.g., by using a consumption tax), I personally see little value to be gained by retaining this complex arrangement. I think it likely that, for administrative reasons, some catastrophic insurance (especially those using PPO models) may offer premium discounts to encourage the use of dedicated savings accounts.

In short, it might well be possible and preferable to “fold in” MSA and PSA models into a system of credits useable for a wide variety of plans. It may be helpful in reducing the value of credits at higher income to reduce them, not to zero, but to the value of the tax exclusion at the income level where the schedule of reductions yields a credit equal to the value of the exclusion. Thus there could be a modest credit (a modest increase in the excluded income as income rises for those who obtain some health insurance, including MSA type insurance) across all households.

While extension of coverage of a moderate amount to those who are uninsured will stimulate health spending, that increase is likely to be small relative to spending increases for the remainder of the population with other causes

and to a considerable extent the desired effect of coverage extended to people previously thought to forego needed care. However, rapid growth of medical spending would in itself imply growth in the level of income excluded from taxation to pay for such necessities that is more rapid than the growth in income itself. The net effect would, at least to some extent, be what we want to avoid: higher marginal tax rates paid by a shrinking proportion of the population.

If it is possible to implement methods to show the growth of medical spending that households do more than harm, one should do so. The most obvious candidate for doing this is limiting the tax exclusion. We need to have modest expectations here. The drive from demand for the new technology that can prolong the length of life and improve the quality of life is both strong and appropriate, and research only assures us that reducing excessive insurance will lower the level of cost, not necessarily their secular rate of growth. But some type of limiting the growth in the value of the exclusion should be possible.

Conclusion

While any rationale for the current hodge-podge of tax exclusions and deductions for health benefits is hard to discover, there are ways to incorporate an alternative, less distortive set of credits into a model of tax reform. The current system yields some results (or, at least, quasi-results), which makes it politically desirable despite its inefficiency, inequity, and complexity. Perhaps incorporating the alternative model into a new system can furnish the example that will make it possible for the older system to sunset, and the newer one to take its place.

Figure 1

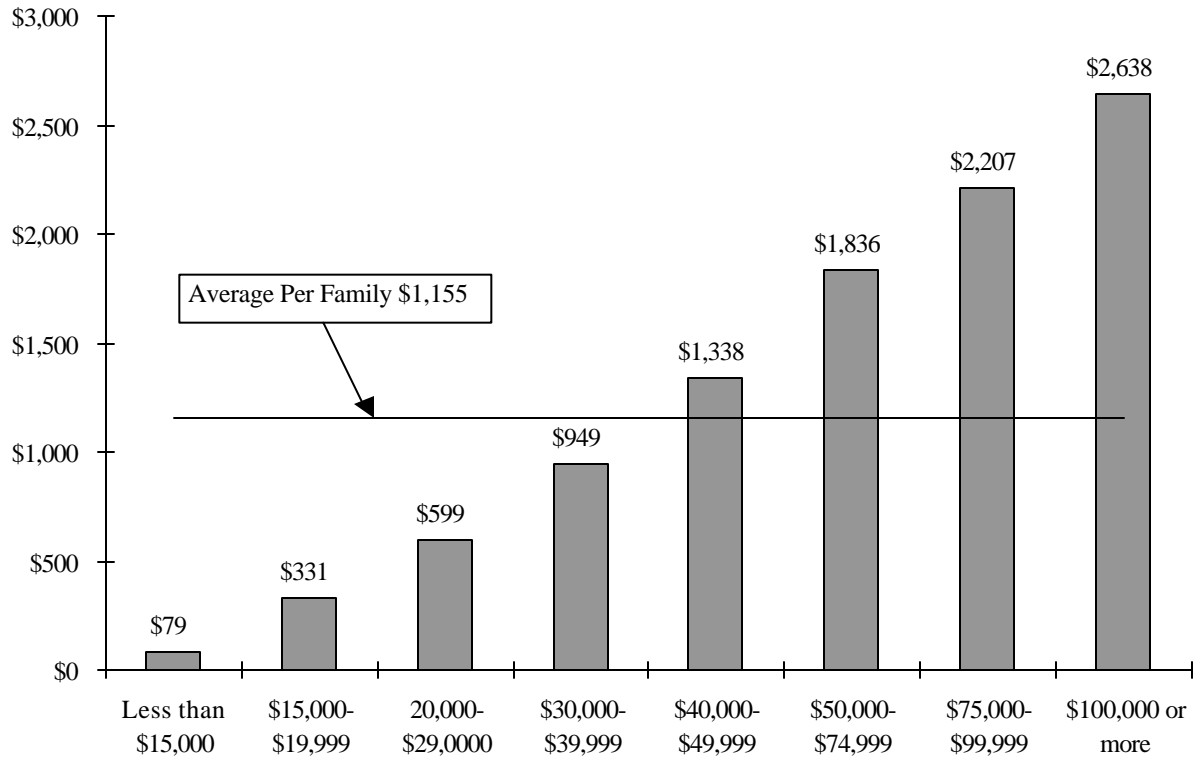
Tax Benefits for the Purchase of Employer-Sponsored Health Insurance¹⁵

Table 1*

Any Private or Employment-Based Health Insurance by Family Poverty Level, 1999

*Ages 0-64 without Medicare coverage (N=115,474)**Percent of those in poverty category*

Family income level (% of poverty level)	Percent with Some Private or Employment-Based Health Insurance
Under 100%	26.3%
100% to 124%	45.7%
125% to 149%	51.8%
150% to 174%	58.0%
175% to 199%	66.2%
200% to 249%	73.2%
250% to 299%	80.1%
300% to 399%	85.8%
400% to 499%	89.1%
500% and over	92.4%
Total	74.2%

**Note: Using post-1996 CPS health insurance variables and appropriate CPS March Supplement weights to reflect national population. Data set is CPS March Supplement for 2000, reflecting coverage in 1999. Any private or employment-based health insurance is defined as employment-based or individually purchased coverage, as a policyholder or a dependent, and includes CHAMPUS, CHAMPVA, VA, and military health care.*

Table 2

Private Out-of-Pocket Expenses as Percent of National Health Expenses, 1988-2001, and Projected 2002-2012

1988	1993	2000	2001	2002	2003	2008	2012
21.3%	16.6%	14.9%	14.4%	14.1%	13.9%	13.4%	12.9%

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