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WHAT THE CBO SAYS ABOUT THE TAX TREATMENT OF EMPLOYMENT-BASED HEALTH INSURANCE

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The Congressional Budget Office (CBO) recently issued a major report on the tax treatment of health insurance which lends strong support for scholars and lawmakers who advocate a major overhaul of the tax treatment of health care benefits and spending. In its March 1994 report, "The Tax Treatment of Employment Based Health Insurance," the CBO analyzes the current tax relief for employer-provided health benefits and how it affects the cost and availability of health insurance. The CBO then compares today's system with a nationalized system, a tax credit system, and other options embodied in leading legislative proposals.

The CBO's findings not only support The Heritage Foundation's criticisms of the current tax treatment of health insurance,[1] but also are of direct interest to Members of Congress considering legislative reforms such as the "Consumer Choice Health Security Act" (S. 1743, H.R. 3698) and other tax-based health care reforms. S. 1743 was introduced last year by Senator Don Nickles (R-OK) with the support of 24 Senators, including most of the Senate Republican Leadership—among them Robert Dole, Thad Cochran, Trent Lott, and Alan Simpson. The House version, introduced by Representative Cliff Stearns (R-FL), shares similar Republican leadership support, including Newt Gingrich, Richard Armey, Henry Hyde, and Duncan Hunter.[2]

In reviewing the current tax policy and three major alternatives for reforming the present tax treatment of employment-based insurance, the CBO study reinforces several findings of Heritage Foundation scholars concerning the need to change the tax treatment of health insurance by creating a new tax credit to give Americans more personal choice of health care services, the ability of families to own their health plan and keep it from job to job, and to ensure more genuine competition among insurance carriers and providers.

1 Stuart M. Butler, Ph.D., "A Policy Maker's Guide to The Health Care Crisis, Part I: The Debate Over Reform," Heritage Foundation *Talking Points*, February 12, 1992, p. 5.

2 For a description of this legislation, see Stuart M. Butler and Edmund F. Haislmaier, "The Consumer Choice Health Security Act (S. 1743, H.R. 3698)," Heritage Foundation *Issue Bulletin* No. 186, December 23, 1993, p. 1.

CBO Observation #1: The current tax treatment of employer-based insurance undermines portability of health insurance.

For most working Americans to obtain any tax relief for health care costs, their employer must earmark part of the worker's compensation to pay for a health insurance policy that the employer—not the worker—then owns. This tax break effectively ties health insurance to the place of work. As the CBO explains:

> Tying health insurance to employment causes further inefficiencies. Workers who are sick or who have a sick family member can get trapped in their jobs because most new insurance policies will not cover the "preexisting condition." Finally, because insurance is tied to one's job, it is inherently insecure. Employees can lose their insurance if they lose their jobs or if their employers stop carrying insurance.[3]

When employees get sick during their employment they are often discouraged from seeking better jobs because they must give up their current insurance and requalify for coverage. But insurance plans often deny coverage for pre-existing conditions or impose waiting periods before coverage kicks in. Significantly, only health insurance is tied to the place of employment in this way. All other major forms of insurance such as automobile, homeowner's, mortgage, and life are not normally tied to an individual's place of work. This constricts the market and eliminates a worker's personal ownership of an insurance plan.

CBO Observation #2: The current tax treatment of employer-based health insurance fuels higher health care costs.

The CBO states:

> Employment based health insurance is valued by businesses and workers and receives support from the federal government through tax subsidies. Yet those subsidies exacerbate the high cost of health care as well as some of the problems of the uninsured people. Because the amount of the subsidy increases with the size of the health insurance premium, the subsidy not only encourages employers to provide insurance but also encourages them to provide the most expensive health insurance policies. Employees who have a choice among health insurance options are more likely to choose more expensive plans because they have to pay only part of the additional costs.[4]

It is therefore natural for employers to seek a comprehensive package, because the more comprehensive and expensive such a benefit package is, the larger the tax exclusion on those benefits for the employees. Further, employers are more inclined to agree to tax-free fringe benefits, such as health insurance, rather than taxable cash income. The reason: the same *post-tax* value of fringe benefit compensation is less costly for the employer to provide.

Ironically and unfortunately, over time these incentives harm employees. Not only are employees deprived of proportionate wage increases, but because they are in effect shielded from the true cost of health care they have much less incentive to seek good value in health care or to question medi-

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3 Congressional Budget Office, "The Tax Treatment of Employment Based Health Insurance," March 1994, pp. xii-xiii, 3.

4 *Ibid.*, p. xii.

cal prices or the need for expensive medical tests and procedures. As a result, the utilization of medical care has risen, including the utilization of services that may be of only marginal benefit to employees.

CBO Observation #3: Lower-income individuals and families are helped least by the current system of tax relief.

The CBO confirms a recent study by Lewin-VHI, the nation's leading health econometrics firm, showing that individuals and families at the high end of the income scale realize far greater tax relief under the current employment-based health insurance system, while middle- and lower-income workers benefit far less—and many not at all. The CBO states:

> [F]amilies with higher incomes receive larger tax subsidies because they are in higher income tax brackets. Thus, the reduction in taxable income that the exclusion produces is worth more to them on average than it is to families in lower tax brackets. Because the income tax is progressive, people with relatively high incomes (and high tax rates), who may need the least assistance in getting health insurance, benefit the most from the tax exclusion.[5]

Lewin-VHI conducted a study on behalf of The Heritage Foundation and found that, in 1991, the tax exclusion (combined state and federal) was worth far more to upper-income groups than middle- and lower-income groups. Specifically, households with income of $50,000 or greater received approximately $35 billion in tax relief on health care while households earning $20,000 or less received only $2.7 billion in tax relief.[6] The typical family earning $100,000 in income in 1991 enjoyed a federal tax break for health care worth an average of $1,463. But for a family earning $10,000 or less, the value was just $50.

What this means is that the value of the tax exclusion is heavily skewed toward upper-income earners. This in turn means the government gives little or no help to those lower-paid working Americans who find it hardest to afford medical care.

CBO Observation #4: Employment-based health insurance not only hides the true cost of health care but also who pays for this benefit.

A major misperception by the American public is that employment-based health insurance is somehow a "free" benefit. The CBO report corrects that illusion. As the CBO states:

> An often overlooked point is that the employer share of the cost of "employer provided" health insurance is ultimately passed on to workers in the form of lower wages and reductions in fringe benefits other than health insurance. . . .[T]his study calls health insurance that employees receive at work "employment based" rather than "employer provided."[7]

Businesses large and small can survive only if they are profitable. These profits and the revenues retained by the firm generally are distributed among shareholders, re-invested in the day-to-day operations of the business (improved machinery, increased research and development, and so forth),

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5 *Ibid.* pp. xiv, 4.

6 Chart on the State and Federal Tax Expenditures for Private Health Insurance Coverage in 1992, based on the Health Benefits Simulation Model (HBSM). Study for The Heritage Foundation by Lewin-VHI, Fairfax, Virginia.

7 CBO, *op. cit.*, Introduction.

and distributed among employees as wages, salaries, and fringe benefits. Thus health insurance benefits must be paid for by money that otherwise would go to stockholders, the investment budget, or to employees in wages. A review of the economic literature by Lewin-VHI shows that on average some 88 percent of the cost of health benefits is actually paid for by lower employee compensation.[8] The number-one reason, especially among small employers, why certain firms currently do not provide health insurance is the cost. A majority of businesses in America are considered to be small businesses with 25 or fewer employees, often operating on narrow profit margins. Since smaller insurance risk pools to cover employees in these firms generally involve substantially higher premiums, these employers cannot afford to provide health insurance to their workers. If such an employer were to offer health insurance as part of a compensation package to employees, the trade-off inevitably would mean lower wages or salaries to help offset the cost of providing that benefit.

A Lewin-VHI analysis for The Heritage Foundation points out that just as existing health benefits are not a free lunch for employees, neither would be a mandate on employers to provide health insurance. The Lewin-VHI study, which projected the 1998 impact on employee wages of the Clinton Administration's proposed employer mandate, found that workers would experience a net total cut in wages of $18.8 billion that year to pay for the mandated benefit.[9] Such a mandated benefit would especially have an adverse impact on jobs in the manufacturing, retail trade, and service industries. Combined, these three industries would lose approximately 229,000 jobs in 1998, according to Lewin-VHI.

CBO Observation #5: To achieve true comprehensive health care reform, federal policy makers need to address the tax code.

As CBO mentions in its summary, "Modifying the treatment of employment based health insurance could be an important component of efforts to address the problems of the U.S. health care system."[10] Not only does the current tax exclusion equate to an approximate $74 billion loss in federal revenues for 1994, it does little to encourage cost containment on the part of consumers, and providers of care. "Limiting the tax exclusion is therefore an important way to put downward pressure on health insurance premiums."[11] As the CBO reaffirms, the health care financing policy which directly impacts most Americans is the exclusion of the employers' contributions for employee health insurance from income taxes and Social Security payroll taxes.

CBO Observation #6: Community rating, a common feature of employment-based health insurance, has negative consequences for younger Americans with lower incomes who pursue healthy lifestyles.

In general, all employees working for the same firm are charged the same level of premiums for the same type of coverage. They may pay all or part of the premium, or their payment may be in the form of lower cash compensation. Charging the same premium for a certain level of insurance to everyone in a "community" (in this case, the employees of a firm) is a practice known as community rating. Such an arrangement presents several inequities. According to the CBO:

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8 See Stuart M. Butler, "How the Clinton and Nickles-Stearns Health Bills Would Affect American Workers," Heritage Foundation *Issue Bulletin* No. 188, April 11, 1994.

9 *Ibid.*

10 CBO, *op. cit.* p. xiv.

11 *Ibid.*, p. 3.

> [Community rating] . . . establishes some questionable transfers of resources. For example, under community rating, young workers who tend to have lower incomes subsidize older workers with higher incomes. In addition, because of adverse selection, community rating is inherently unstable when participation is voluntary.[12]

What this second point means is that because generally low-risk young workers end up paying far more in premiums under community rating than the benefits they expect to receive, they will tend to pull out of such coverage if they have the chance. For example, take the state of New York, which has adopted a community rating requirement for all health insurers wishing to do business in the state. When New York's pure community rating requirement went into effect in April 1993, the state insurance department estimated that the average 30-year-old male could expect a premium increase of 170 percent, while a 60-year-old male might see a decrease of 45 percent.[13] This hike in insurance rates for younger workers made it prohibitively expensive for many. Community-rating arrangements also penalize responsible individuals who practice prudent living habits by charging them the same premiums as individuals who purposely engage in non-healthy habits, such as smoking, excessive drinking, or illegal drug use.

In contrast, the Nickles-Stearns legislation allows insurers to charge individuals premiums based only on age, gender, and geographic location. This sound approach is referred to as "limited underwriting" or "modified experience rating," and allows Americans to buy insurance with premiums much more in line with their real insurance risk. In addition, the Nickles-Stearns bill encourages preventive care by permitting insurers to offer a discount to individuals and families pursuing a healthy life style.

CBO Observation #7: Establishing an individual tax credit is a viable alternative in reforming the U.S. health care system.

The true "crisis" in the current health care system is the way in which health care is financed. The CBO report recognizes the tax credit mechanism as a viable approach. Explains the CBO:

> Instead of allowing an unlimited tax exclusion for the cost of premiums, the government could convey the subsidy for health insurance through a refundable tax credit. The amount of the tax credit can be varied by income level and family status to control the cost of the subsidy and target the benefits.[14]

As Heritage scholars also have observed, the most prudent way to assist lower-income Americans to buy into the market on the same terms as all other Americans is to reform the tax system.[15] Because the current tax code favors only health insurance that is employment-based, the less fortunate are not able to obtain health insurance on an affordable basis in an open and private market.

Some health care reform proposals unwisely would reform the tax code by placing a "cap" on the amount of employer-sponsored health benefits that could be excluded from an employee's taxable income. Legislation that would impose a cap includes S. 1770, sponsored by Senator John Chafee (R-RI). The problem with this approach is that the employee ends up losing. Not only is the em-

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12 *Ibid.*, p. 15.

13 HIAA, *Community Rating: Why It's Not the Answer*, December 22, 1993.

14 *Ibid.*, p. 44.

15 Edmund F. Haislmaier, "A Policy Maker's Guide to the Health Care Crisis, Part IV: The Right Road to Health Insurance Reform," Heritage Foundation *Talking Points*, November 5, 1992, p. 17.

ployee denied a choice of level of benefits, he is now subject to a new tax on the benefits in excess of the tax cap. The employee will either pay this new tax directly or else the employer will pass it down in the form of lower wages.

The Nickles-Stearns approach takes a very different approach, by exchanging the entire tax exclusion system for tax relief in the form of a refundable tax credit for health insurance bought by the individual or purchased on a worker's behalf by the employer, or for insurance purchased by the self-employed. Out-of-pocket expenses and contributions to a medical savings account also will be eligible for the credit. The refundable nature of the credit means it also would be available for the unemployed and for those below the tax threshold—if the available tax credit were to exceed a family's tax liability, that family would receive a voucher. In addition, the tax credit is partially financed through proposed Medicare and Medicaid savings equivalent to $133 billion over five years.

Thanks to this design, the Nickles-Stearns tax credit approach would mean a net tax cut for every income group, even among the working poor. As the following chart, assembled from a Lewin-VHI study shows, after taking into account this tax reform, the Nickles-Stearns tax credit is a net tax cut for all income groups, but middle- and lower-income families would receive most of the new tax relief.[16]

Projected Average Net Value in 1998 of Nickles-Stearns Individual Tax Credit, Compared with Tax Exclusion, by Family Income[a]

		Family Income								
	All Households	Less Than $10,000	$10,000-$14,999	$15,000-$19,999	$20,000-$29,999	$30,000-$39,999	$40,000-$49,999	$50,000-$75,999	$75,000-$99,999	$100,000 or More
Value of Current Tax Exclusion, at State and Federal Level[b]	1,183	65	183	355	626	982	1,270	1,880	2,443	2,825
Value of Nickles-Stearns Tax Credit	2,050	1,631	1,883	1,805	1,748	1,959	1,997	2,269	2,483	2,893

a Estimates are for the initial year of program implementation. Includes only families headed by persons under age 65.
b Includes the additional taxes paid on employer benefits converted to income under Nickles-Stearns including: federal income taxes; the employee share of OASDI and HI payroll taxes; and state income taxes.
Source: Lewin-VHI estimates using the Health Benefits Simulation Model (HBSM).

CBO Observation #8: A tax credit mechanism can increase economic efficiency, reduce unemployment, reduce cost-shifting, and make realistic strides at achieving universal coverage.

The CBO notes:

> By providing a larger subsidy for low-income families, a credit would encourage more people to secure health insurance, reduce adverse selection, and discourage free riders. Workers at small firms, however, have lower wages on average and would therefore qualify for larger average tax credits than workers at large firms.[17]

16 Stuart M. Butler, "How the Clinton and Nickles-Stearns Health Bills Would Affect American Workers," Heritage Foundation *Issue Bulletin* No. 188, April 11, 1994, p. 7.

17 CBO, *op. cit.*, p. 45.

A tax credit will increase access to health insurance by directing the benefits of the credit to the segment of the population that otherwise would remain uninsured absent a subsidy. And while the goal of adequate coverage for all who want it is realized more efficiently, at the same time a tax credit approach also increases the numbers in the labor force and thus contributes directly to welfare reform and other goals. Explains the CBO:

> [T]he credit would also reduce the current disincentive for welfare recipients to enter the work force. At present, welfare recipients can lose most of their benefits when they go to work . . . . [A] tax credit would reduce this penalty.[18]

The CBO report gives legislators a valuable tool to understand the real crisis in health care: how it is currently financed. As The Heritage Foundation has pointed out repeatedly since 1988, employees end up the losers under an employment-based system. Lawmakers should not be afraid to go home and explain to their constituents that it is working people, not employers, who really pay for health insurance. By addressing the root cause of the financing problem (repealing the current tax exclusion of employer-provided health benefits and replacing it with individual tax credits), the Nickles-Stearns legislation offers Americans the necessary components of health care reform: simplicity, affordability, security, portability, availability, and quality.

The American people would be well-served if Congress and the Administration carefully examined the CBO report.

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18 *Ibid.*, p. 46.