

Our Unhealthy Tax Code

If progressives want to cure what ails the health care system, they first have to put the tax code on the examination table.

American health care is beset by a well-known litany of problems. Forty-six million Americans lack health insurance, resulting in, according to the Institute of Medicine, 18,000 avoidable deaths each year. At the same time, the principal mechanism for providing health insurance, through employers, is unraveling: the number of non-elderly Americans without employer-sponsored insurance jumped by 15 million from 2000 to 2004. Health costs are also an increasingly larger share of the economy and rising rapidly. Premiums have jumped 73 percent since 2000 and aggregate health spending is projected to increase by another 49 percent by 2015, when total spending will reach 20 percent of U.S. GDP. We could, as a nation, choose to spend that much of our total income on health care, and one would expect that the country, in return, would enjoy some of the best health outcomes

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in the world. Unfortunately, that's not the case. Not only do we spend more than any other country on health care, nearly 50 percent more per capita than the second highest spending nation, but citizens in 28 other countries have a higher life expectancy and 33 other nations have lower infant mortality rates.

If this were a government-run health care system, the voting public and policymakers would be up in arms. Yet, perhaps because health care is largely perceived as a private-sector concern, there is relative quiet: while voters tell pollsters that it is a top priority, there appears not to be comparable political pressure for serious reform or any fundamental change in the government's involvement, either in the provision or funding of health care. This is in part because much of the federal government's involvement with the health care system is through the hidden backdoor of the tax code. An important principle for modern progressives is that when the government has to intervene in the marketplace, it should not prop up failure. Yet the federal government is, in fact, deeply involved in perpetuating the current "private" health-care system and all its flaws, spending approximately \$200 billion annually in subsidizing employer-provided insurance. It is the single biggest subsidy in our tax system, more than twice as costly as the mortgage interest deduction. The only government programs that cost more are Social Security, national defense, and Medicare.

The fact that the tax subsidy, which supports the employer-sponsored system, is better than nothing is a feeble excuse for resisting *any* changes to the status quo. This massive program of tax breaks is ineffective and regressive, wasting money on those who have health insurance while doing little for those who can barely afford it and nothing for those without it at all. Precise statistics are not available, but a reasonable estimate holds that the tax subsidy pays for about \$4,000 of the insurance premiums for a high-income family, compared to less than \$1,000 for a low-income family and \$1,500 for a middle-income family. For higher-income workers who would likely have purchased health insurance anyway, the \$4,000 is a pure windfall. For lower-income workers, the \$1,000 subsidy may not be enough of an incentive to purchase health insurance. This is part of the reason why workers with lower incomes are more likely to be uninsured and the firms that hire them are less likely to offer health insurance. The tax code also increases wasteful and unnecessary spending by subsidizing health insurance plans that discourage health consumers from being cost-conscious. In the final diagnosis, the tax code is literally making America sick—squandering taxpayer dollars on a health care subsidy system that is failing to provide quality health care to all Americans.

A single-payer national healthcare system would, by definition, remedy the problem, but it is unlikely to happen anytime soon, if ever at all. Beyond the

political limitations, it is also an open question whether a single-payer system would be the most efficient way to provide quality health care for all Americans. In the meantime, reforming health care will come down to a set of incremental changes that build on the current system. But that does not mean that change cannot be ambitious. As Massachusetts has shown, achieving a plan for universal health insurance coverage need not wait for the establishment of single-payer government insurance like Medicare or a national healthcare system like the United Kingdom's.

In fact, if we turned our irrational health tax subsidies right-side up—by curbing subsidies for higher-income workers and those with more generous health insurance plans—we could raise tens of billions of dollars annually, money that could go toward increasing access to health insurance. Taking it a step further, we could scrap the current deduction altogether and replace it with progressive tax credits that, together with other changes, would ensure that every American has affordable health insurance. In either case, reducing subsidies for pricey plans would likely lead to a health insurance system that includes more cost sharing, promotes more consumer consciousness and plays a modest, but potentially meaningful, role in restraining health spending. And, unlike President George W. Bush's Health Savings Account (HSA) proposal, this cost sharing would not require regressive tax cuts and would not be based on a one-size-fits-all, government-prescribed high-deductible plan.

Tax reform is not all there is to health care reform. Many other elements are important, even essential, ranging from ensuring access to affordable health insurance for the chronically ill and small businesses to the promotion of prevention and health information technology. But tax reform is a critical missing link in the way most politicians—progressives and conservatives alike—have thought about confronting America's health care crisis. When conservatives look at the tax code's effect on health care, they all too often use the current crisis as a pretext to cut taxes and shift risk onto individuals; some even want to eliminate *all* the tax incentives for the employer-sponsored system without creating any meaningful alternative.

On the other hand, too many progressives are so (rightly) concerned about taking any step backward in our health system that they are reluctant to open a discussion about the tax code. Some progressives also may say that such a plan

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is timid, that the United States should move aggressively toward a Canadian-style national health service. But both approaches suffer from a similar flaw: they are little more than a parlor game, drawing the perfect system on a blank slate. On the contrary, any meaningful attempts to change the health system have to start from where it is today. For all its flaws, we are starting from a system centered around employer-provided health insurance. Anything that undermines this system without putting in place a comprehensive alternative could easily leave us in worse shape.

The Accidental Birth of our Health Care System

To grasp the centrality of tax policy to health care, one must understand the roots of the current health care system. Employer-sponsored health insurance evolved by accident. During World War II, labor was predictably scarce. But in an effort to limit inflation, President Franklin Roosevelt had imposed wage and price controls, meaning that employers could not attract workers with higher wages. So instead, employers attempted to outbid each other by offering health insurance and other benefits as incentives to prospective workers. Wage controls were lifted after peace was restored, but the employer-sponsored system persisted.

This historical accident significantly helped average Americans obtain health care; prior to World War II, health insurance was rare and medical care was often prohibitively expensive. Employer-provided insurance schemes pooled groups of employees together, making it possible to spread risks, reduce administrative costs, and enable employers to bargain for better deals on insurance rates. Of course, these advantages could have been achieved by numerous other pooling arrangements, such as purchasing insurance through churches, labor unions, or professional associations. But one factor made it virtually certain that the employer-provided system would stick: in 1954 Congress changed the tax code to formalize the practice of effectively treating employer contributions to health insurance premiums as tax-deductible, with the tax benefits accruing almost entirely to employees. Specifically, it rendered employer payments for health insurance benefits income- and payroll-tax-free to employees. (Although the company also gets to deduct the insurance premiums, this is not a special tax benefit for the company since all of its labor costs, including wages, are deducted when calculating net profits.)

To be sure, even in the absence of tax breaks the employer system would be more attractive to many people than purchasing insurance directly from an insurance company. The individual market for health insurance functions poorly: premiums are high; coverage is limited; younger, healthier people often

opt out, thinking they can fall back on emergency-room care if needed; and many people with chronic illnesses or other pre-existing conditions are denied coverage all together or get insurance plans that cover everything but what ails them. As a result, nearly 90 percent of all private health insurance is through employer-sponsored plans.

But the employer system also has serious flaws, and rising costs are leading many employers to forgo coverage entirely. The employer-sponsored system is very uneven: while 98 percent of large firms offer health insurance to their employees, only 59 percent of small firms do. And firms that hire more low-wage workers are substantially less likely to offer insurance, partly because many low-wage families have the option of Medicaid and S-CHIP (at least for their children) and get few if any tax benefits from health insurance. If they do get insurance, the plans are less generous and their employers pay a smaller share of the premiums. In total, the uninsured tend to have lower incomes. Our unhealthy tax system makes an important contribution to all of these injustices.

The Upside-Down Health-Tax System

At the heart of progressive notions of equality and justice is the principle that those with more of an ability to pay for a social good should shoulder a larger share of the burden through higher taxes. Providing tax incentives for health insurance, like tax incentives for home mortgages or college tuition, effectively overrides this principle: a person who is better off because he has a job with great health benefits could end up paying less in taxes than someone stuck in a dead-end job without such benefits. Sacrificing fairness and progressivity can often be justified in order to further other important social goals. But the form these health tax incentives have taken is both unnecessarily unfair and inefficient.

Consider the situation of three representative Americans in the current system. An investment banker, for instance, might enroll in a family plan that costs \$13,000, with her employer paying 80 percent of the premium, or \$10,400. The employer contribution is tax free, saving her nearly \$4,000 in taxes (the \$10,400 employer contribution multiplied by her marginal tax rate which is 35 percent for income taxes plus 2.9 percent for Medicare payroll taxes). In effect, it only costs 70 cents for every one dollar of health insurance she purchases.

The current system works well for the investment banker, but consider how it treats the man who cleans her office. There is a good chance he will not get, or choose to take, any health insurance from his employer, in which case he will receive no tax breaks at all. But if the cleaner does get insurance, his family plan might cost \$7,000, with the employer picking up 70 percent of the

cost (a typical package for low-wage service workers). Not only does he get less money in tax-free employer premium payments, he is also in a lower tax bracket, so the money he does receive does not reduce his taxes by as much. As a result he saves only about \$1,000. This smaller subsidy effectively means that the cleaner pays a higher price for health insurance: eighty-six cents for every one dollar of health insurance he purchases. As for the investment banker's administrative assistant, making a typical middle-class income, she would fall somewhere between these two extremes, although saving an amount closer to the cleaner at about \$1,500 annually.

A government health-insurance program that provides a \$1,000 subsidy for a cleaner, \$1,500 for an administrative assistant, and \$4,000 for an investment banker is plainly unfair, but why does it persist? Imagine—as economists Joel Slemrod and Jon Bakija do in a thought experiment—if we replaced the current system with a financially equivalent one in which, instead of tax deductions, everyone receives a flat \$4,000 off their taxes, but some pay “tax penalties” that are a function of their income and their employer's contribution to their health insurance. If your income is above \$500,000 and you have a generous health insurance policy, you are in luck: you do not have any tax penalty. If you make only \$50,000 and have an average health insurance plan, you pay a tax penalty of \$2,500. If your income falls and you get a lousy health insurance plan, your penalty goes up to \$3,000. If your employer does not offer you health insurance, your penalty jumps to \$4,000. It is hard to imagine this system lasting very long. But because these inequitable subsidies are distributed opaquely through the tax system, rather than directly through government outlays, few complain.

Not Just Unfair, But Also Inefficient

The unhealthy tax code is not just inequitable; it also wastes precious dollars that could be better spent elsewhere in the health system. The subsidy is unnecessarily large for higher-income workers: the investment banker does not need a \$4,000 subsidy—or 30 percent off the price of health insurance—to be encouraged to buy it. And the subsidy is too small for many lower-income workers: the \$1,000 subsidy for the cleaner is not sufficient to make health insurance affordable for him.

This is not to say that the tax break is of no value. With no subsidy at all, some employers would drop their health insurance plans and some of the 174 million people with employer-sponsored health insurance would lose it, especially those working at smaller companies that are already on the verge of dropping their coverage. But the tax break doesn't provide a sufficiently

high bang-for-the-buck in stimulating additional insurance. If the subsidy were limited for higher-income families, virtually the same number of people would get health insurance at substantially lower federal cost. And expanding the subsidy for more moderate-income workers would be a relatively cost-effective way to expand coverage.

Another inefficiency of the tax system is that it continues to provide subsidies for insurance no matter how generous the plan is. The tax subsidy for a basic health insurance plan that has an employer contribution of \$4,000 is just as large as the *added* subsidy for a plan that has an employer contribution which grows from \$8,000 for a good health insurance plan to \$12,000 for a more generous plan. While it would be nice for everyone to have a generous health plan, our limited resources would be more effective if they provided larger subsidies to help make decent health insurance affordable and smaller subsidies to go from good plans to more generous ones.

This incentive is compounded by an asymmetry in the tax code: if your employer pays \$1,000 in premiums to your insurance company, that money is effectively tax deductible to you. But if your employer raises your salary by \$1,000 and you use the extra money to pay for medical bills, you generally will not get a tax deduction. As a result, many people end up with more-generous health insurance plans that they would otherwise choose to have. These plans have lower deductibles, lower copayments, and lower coinsurance and are often focused around providing first-dollar coverage for routine medical expenses, rather than genuine insurance. As a result, individuals in the health system are often spending someone else's money, which is never a recipe for cost consciousness. Unfortunately, ultimately it is not really someone else's money: the cost is paid in higher premiums, which in turn are reflected in lower wages.

While the notion that anyone can be "overinsured" may be jarring, the idea that many people are underpaid should be easier to accept. Although one might hope that everyone could be paid higher wages and better health benefits, even higher compensation would not repeal the basic rules of arithmetic: the more an individual spends on the health care, the less they have to spend on everything else. The tax system stacks the deck in favor of health care. Furthermore, the issue of "overinsurance" and the problem of underinsurance are related. Anything that leads to more health spending by some drives up the cost of insurance for everyone, making it less affordable and thus increasing the number of uninsured.

The critical question is whether people cut back on needed care when they have to pay more of their own money. The large-scale Rand Health Insurance experiment conducted in the 1970s provides what is still the best evidence on this

question. The experiment randomly assigned individuals to health insurance plans with different levels of cost-sharing. People in plans that required them to pay more of the costs themselves reduced their spending with little evidence of any adverse effect on their health, with the important exceptions of lower-income and chronically ill people, who appeared to cut back on some preventative care and as a result had somewhat worse health outcomes.

This is consistent with the finding that many people get little value out of an *additional* dollar spent on health care—a painful paradox in a country where tens of millions of uninsured do not have access to the additional medical services they need. Jack Wennberg and his colleagues at Dartmouth Medical School, for example, have done a series of groundbreaking studies finding that the tremendous variations in the level and intensity of medical services across counties is largely uncorrelated with health outcomes. This phenomenon is sometimes described by saying that much of America’s healthcare is practiced on the “flat of the curve,” with little additional benefit for large amounts of additional spending.

To be sure, while the tax system certainly contributes to higher health spending, one should not exaggerate its role. Even in the absence of any tax incentives, Americans—like people around the world—generally prefer not to pay many health costs out-of-pocket and instead prepay much of the cost through an insurance company. To the degree this leads insurance companies to do a better job bargaining for lower prices, this preference makes perfect sense. And, even if tax changes led to greater cost-sharing, this would still have only a limited impact on total health spending, for the simple reason that 10 percent of Americans are responsible for 70 percent of health costs. Any insurance plan, with or without greater cost sharing, would pick up most of the tab for expensive procedures like chemotherapy or heart-bypass surgery.

Everything else being equal, encouraging greater cost-sharing is worthwhile, although the cost-sharing should be limited for low-income families. The health cost and efficiency challenge is simply too large to address with a single step, but that is all the more reason to have as many steps as possible in our overall reform. But cost reductions should be part of a plan to improve the health system, not a pretext for a proposal that would reduce coverage and impede the functioning of the health insurance system. Yet this is precisely what President Bush’s HSA proposal would do.

Health Savings Accounts Won’t Save Health Care

In the face of a tax code that creates incentives to spend more and subsidizes those who least need help, President Bush has put forward a health plan, based

on so-called “consumer-driven health care,” that would actually make this situation worse. This health plan, predictably, is based on his two favorite panaceas: private accounts, in this case HSAs, and tax breaks tilted towards the most fortunate. The 2003 prescription drug bill established HSAs as a way for individuals with qualified, high-deductible plans (which in 2006 requires a deductible of at least \$1,050 for an individual and \$2,100 for a family) to save in a tax-favored savings account. Contributions to HSAs are tax-deductible, the funds accumulate tax-free, and all withdrawals for qualified medical expenses can be made without incurring any tax liability (in contrast, IRAs and 401(k)s have either tax-deductible contributions or tax-deductible withdrawals, but never both). Unlike IRAs, HSAs have no income limits, and thus they offer a particularly lucrative tax-sheltering opportunity for high-income families. In addition, President Bush has proposed adding \$15 billion in annual tax breaks to support HSAs. Claiming that “one of the greatest obstacles to expansion of HSAs is the tax code,” he proposes to expand the tax benefits for HSAs and high-deductible insurance plans purchased directly in the individual market by making even more health costs tax-deductible.

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President Bush’s HSA package would make our current system even more regressive by subsidizing savings for wealthy families. For example, he is asking Congress to raise the annual amount a family can save in an HSA from a maximum of \$5,450 under current law to a maximum of \$10,500. Only a tiny minority of American families is saving so much that they would benefit from this higher contribution limit. These families could accumulate hundreds of thousands of dollars tax free, far more than needed to pay their health costs, and in doing so achieve the President’s stated goal of “reforming” the health system. This is less a reform than an expensive tax giveaway for the most fortunate: high-income families could easily get tax breaks that are 20 times as large as middle-class families. As Congressman Rahm Emanuel puts it, HSAs are “more wealth care than health care.”

Not only would President Bush’s proposals have limited upside in controlling health spending; they, as designed, could even end up *increasing* health spending, thanks to all the new tax incentives that encourage greater health spending by people already enrolled in HSAs. Perhaps more alarming, healthier individuals would opt into high-deductible plans and the individual market, driving up costs for everyone left in the old system. The Bush plan also would

undermine the one pooling mechanism that works tolerably well, the employer-sponsored system, without providing any replacement pooling mechanism. As a result, despite spending \$15 billion annually, the plan would do little to reduce the number of uninsured and could even end up swelling their ranks. By creating a new tax deduction for individuals purchasing insurance on their own, the President's proposal would eliminate the added tax incentive to purchase insurance through an employer. MIT economist Jonathan Gruber estimates that 9 million people will be dropped from, or choose to leave, their employer-sponsored coverage as a result of this change. This more than offsets the number of people that would get insurance under the plan, leaving the total number of uninsured approximately 600,000 people higher. In addition, many of the people who would lose their health insurance are sicker than average, while the people that gain health insurance are healthier.

And, ironically, President Bush's proposal—one lauded by free-market conservatives—actually restricts consumer choice. All of the tax breaks are reserved for purchasers of one type of government-approved health insurance, with specific limits on deductibles, out-of-pocket payments, and other aspects of the plan. Even Bush's own Council of Economic Advisers acknowledges in the 2006 *Economic Report of the President* that this one-size-fits-all design may be inappropriate in some cases, like lower-income families who will forgo needed care.

A Progressive Way Forward

Over the past several months, progressive politicians and allied groups have united in their opposition to the President's HSA plan. But few have followed their criticism to its logical conclusion: addressing our unhealthy tax system. The bottom line is that we should spend less subsidizing more expensive insurance and more health care for higher-income people and spend more to help moderate-income families obtain the health insurance they lack.

How can this be done? For one, Congress could cap the amount of health insurance that is tax-deductible and use the savings to expand coverage, say by limiting the deductibility of employer-premium contributions to a certain amount, like \$7,500 for a family policy. Alternatively, it might be more politically feasible to phase the policy in over time by initially setting a higher threshold but not fully indexing it for the growth of premiums for a period of time. In addition, the value of deductibility could be limited for higher-income individuals, either by capping the deduction at 25 percent of the health premium or phasing it down for high earners. Any combination of these approaches could save a sizeable chunk of the current \$200 billion subsidy.

Those savings, in turn, could be used to expand coverage in a variety of ways, such as by guaranteeing Medicaid to all Americans below poverty (or an even higher threshold), by providing progressive tax credits to strengthen the weakest link in the employer-sponsored system (coverage by small businesses) or by funding subsidies for new mechanisms to make insurance affordable for all Americans, like allowing them to buy into a plan like the Federal Employees Health Benefit Plan (FEHBP), the same health plan available to members of Congress.

In such a scenario, there is little risk of undermining the employer-sponsored health system, because the proposal would retain the current structure of tax subsidies for employer-sponsored insurance. Moreover, employers who are currently considering dropping their coverage are probably paying lower shares of their employee premiums and thus would not be affected by lower caps. It is also unlikely that a generous employer who contributes \$10,000 toward annual premiums would drop coverage altogether just because the employee's tax benefit is trimmed. Finally, capping tax benefits could lead some companies to pay workers more in wages and less in insurance coverage, which would reduce overuse of the health system and make the system cheaper for everyone. Unlike HSAs, however, the progressive alternative is not contingent on a specific government-approved form of cost-sharing; instead, individuals and firms are free to shape cost-sharing as they deem best, adapting them to individual tastes and the best evidence of medical effectiveness.

This approach would buy the health care system some time, but would not cure it. To do that, policymakers should consider scrapping the deductibility of health insurance entirely and replacing it with a progressive tax credit. Individuals could count the value of their health insurance as part of their income when calculating their taxes, but they would get a new progressive tax credit instead of a deduction. The tax credit would be the reverse of the current system, more like \$4,000 going to the cleaner and \$1,000 to the investment banker. The tax credits would go to anyone with health insurance, but would not provide additional subsidies for more generous insurance. This could create the basis for a simpler, fairer system of universal health insurance. Although health benefits might be somewhat less generous, higher out-of-pocket costs would be offset by higher wages.

Ultimately, the best plan might include many elements from the recent health reform in Massachusetts while also addressing that scheme's biggest shortcoming, its lack of sufficient funding. Under a plan of this type, people would have the responsibility to ensure that their families are insured—with a penalty for anyone without insurance. At the same time, the federal government

would have the responsibility to make insurance affordable for all through a combination of progressive tax credits, employer mandates (or penalties for firms not offering insurance), a new pooling mechanism for small businesses and higher risk individuals, and expansions in Medicaid. The money saved by ending the tax deductibility of health insurance, plus the existing funding for Medicare and Medicaid, might be enough to pay for a well-designed, universal health-insurance plan. If not, additional funds could be provided through relatively modest tax increases or spending reductions.

Making these changes will not be easy. In the 1980s, Congress rebuffed President Ronald Reagan's bid to cap the amount of health insurance that could be deducted, and just last year, President Bush's tax reform commission was criticized for proposing the same idea. However, what was missing from both proposals was any commitment to use the bulk of the money saved by eliminating the deduction actually would be used to expand and improve access to health insurance.

And let us remember, *no* plan for universal insurance will be easy. The principal goal of universal insurance is to provide more health care for the uninsured and to reimburse them for more of the costs they are currently paying themselves. Even with some savings from better preventative care, reduced visits to emergency rooms to deliver routine care, and reductions in uncompensated care, the total bill for universal insurance is likely to be anywhere from \$50 billion to \$200 billion, depending on the details of the plan and who is doing the cost estimates.

Nevertheless, there are many areas where our tax code's perverse incentives take us in the wrong direction, wasting money and exacerbating inequality across society. Although conservatives talk a lot about efficiency, ultimately their tax policies reflect their values: a desire for an even less progressive distribution of resources and a smaller government. Progressives should focus more on efficiency, not just in the traditional economic sense but also in terms of ensuring that our limited resources are put to the best use in achieving those social goals, like helping families pay for college or health care, that are increasingly being funded through the tax system. There is no better place to start than with our number-one national problem: health care. And if we cure what ails our tax code, making it more progressive and fair, we can put health care within reach for all Americans. ■