THE EFFECT OF THE TAX LAWS ON HEALTH INSURANCE AND MEDICAL COSTS

Statement by

Alice M. Rivlin
Director
Congressional Budget Office

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INTRODUCTION

The federal government provides substantial incentives for the purchase of private health insurance through the tax code. These tax incentives for health insurance are among the most important ways the federal government influences health care in the United States.

In fiscal year 1980, tax subsidies for private health insurance are expected to generate tax expenditures of $10.6 billion for taxpayers at all income levels (Table 1 shows the distribution by income class). Of this amount, $9.6 billion results from the provision that excludes from employees' taxable income any contributions made by their employers for a health or accident insurance plan. These contributions are also fully deductible by the employer. Another $1.0 billion results from the fact that individuals can deduct from taxable income half the first $300 worth of health insurance premiums they pay themselves, plus any remaining health insurance premiums if these premiums and their other out-of-pocket medical expenditures exceed 3 percent of adjusted gross income. In size, the tax expenditures for health insurance exceed all but two other tax expenditures for individuals (see Table 2). In comparison with direct federal expenditures for health care, they rank just behind Medicare and Medicaid (see Table 3).

TABLE 1. RECENT DISTRIBUTION OF TAX EXPENDITURES FOR PRIVATE HEALTH INSURANCE ACROSS INCOME GROUPS

Expanded Income Class (in Thousands of Dollars)	Percent of Tax Expenditures Received by Taxpayers in Indicated Income Class: Exclusion of Employer Contributions for Employee Health Insurance Plans 1977	Deductibility of Individual-Paid Health Insurance Premiums 1978-1979
Below 5	1.6	0.3
5 - 10	8.9	5.7
10 - 15	14.6	13.0
15 - 20	18.5	17.1
20 - 30	27.8	29.6
30 - 50	15.9	24.4
50 - 100	8.2	8.1
100 and over	4.5	1.9

SOURCE: For 1977, Eugene Steuerle and Ronald Hoffman, "Tax Expenditures for Health Care," U.S. Department of the Treasury, Office of Tax Analysis, OTA Paper No. 38 (April 1979). For 1978-1979, Treasury Tax Model, 1979 law at 1978 income levels.

TABLE 2. LEADING TAX EXPENDITURES FOR INDIVIDUALS IN THE FEDERAL BUDGET: FISCAL YEAR 1980, IN BILLIONS OF DOLLARS

Item	Estimated Tax Expenditure
Net Exclusion of Pension Contributions and Earnings For All Plans	15.1
Deductibility of Non-Business State and Local Taxes Excluding Taxes on Owner-Occupied Homes and Gasoline	12.4
PRIVATE HEALTH INSURANCE	10.6
Exclusion of Employer Contributions for Medical Insurance Premiums and Medical Care	(9.6)
Deductibility of Individual-Paid Health Insurance Premiums	(1.0)
Capital Gains (other than Farming, Timber, Iron Ore, and Coal)	10.2
Capital Gains at Death	10.0
Deductibility of Mortgage Interest on Owner-Occupied Homes	9.3

SOURCE: Congressional Budget Office, Five-Year Projections and Alternative Budget Strategies for Fiscal Years 1980-1984, Supplemental Report on Tax Expenditures, (June 1979); and Treasury Tax Model, 1979 Law at 1978 Income Levels.

TABLE 3. TAX EXPENDITURES FOR PRIVATE HEALTH INSURANCE COMPARED WITH DIRECT EXPENDITURE PROGRAMS FOR HEALTH CARE: FISCAL YEAR 1980, IN BILLIONS OF DOLLARS

Program	Estimated Outlays or Expenditures
Medicare	32.1
Medicaid	12.8
TAX EXPENDITURES FOR PRIVATE HEALTH INSURANCE	10.6
Veterans' Health Programs a/	5.9
All Other Health Services Programs Under Health Budget Function (Functional Code 550)	5.0

SOURCE: Congressional Budget Office.

a/ Not in Health Budget Function.

THE RELATIONSHIP BETWEEN TAX INCENTIVES FOR HEALTH INSURANCE AND SPENDING FOR MEDICAL CARE

The current tax treatment of health insurance is of concern not only because of its large and growing cost in terms of lost tax revenues, but also because of its contribution to increasing total spending on medical care in the United States. The tax incentives for health insurance lead to broader insurance coverage, and this in turn helps drive up spending on health care.

Tax Incentives Increase Private Health Insurance Coverage

The current tax subsidies for health insurance lower the cost of coverage, thereby increasing the demand. For employees in the 30 percent tax bracket, for example, the tax provisions reduce the cost of employer-paid health insurance by 30 percent and individual-paid insurance by between 15 and 30 percent. The cost is reduced still further by the exclusion of employer contributions from social security payroll taxes and from state and local income taxes. These cost savings lead people to buy more insurance than they otherwise might.

But perhaps more important, tax subsidies affect demand by providing an incentive for employers and employees to select the most expensive and comprehensive insurance available. This is often insurance that provides first-dollar coverage, in which patients pay no part of any insured expense. Under current tax rules, employees receive little advantage from low-cost

insurance plans (those with limited coverage or substantial cost-sharing by the patient), since everything the employer pays in premiums is excluded from the employee's taxable income. At best, employees with low-cost plans would receive the difference in cost between their plans and more expensive employer-supported ones in taxable wages. More often, these employees would only receive less income. Thus, low-cost plans are put at a competitive disadvantage.

Health Insurance Increases Medical Care Expenditures

Health insurance increases spending on medical care in two ways. First, it makes patients less reluctant to seek medical care. When patients know that all or a large share of the health care they receive will be paid for by insurance, their use of medical services tends to increase. CBO estimates indicate, for example, that an increase in coverage for physicians' services from 75 to 100 percent of insured costs raises the number of visits to doctors' offices by 32 percent.

Second, health insurance encourages doctors and other health care providers to develop and prescribe more costly forms of care. Since both doctors and patients know that all or most of the treatment will be covered by insurance, there are few incentives to economize. Patients want the best care available, and doctors feel free to provide it. If this means a battery of

expensive tests and treatment with high-cost equipment and personnel, this is what doctors prescribe. It may well help the patient, and it also helps protect the doctor against charges of malpractice. So long as the insurance company is willing to pay, no one has an incentive to curb expenditures. This same freedom from economic constraints encourages health care providers to develop new and costly procedures and to expand the intensity and quality of existing services.

It is difficult to sort out how much of this more extensive medical treatment is due to the availability of insurance, and how much of it would be provided in any event because it makes an important contribution to better patient care. For this reason, it is not possible to make a precise numerical estimate of how much the availability of broad health insurance coverage has contributed to higher spending on medical care. It is clear, however, that both patients and doctors would pay closer attention to how much medical treatment is actually worth if insurance paid for less of it. Ultimately, this awareness would lead to less spending on marginal forms of treatment.

ALTERNATIVES TO THE CURRENT TAX TREATMENT OF HEALTH INSURANCE

There are many ways in which the tax laws could be changed to eliminate the current incentives for high-cost health care

and expensive insurance. I will discuss here only a few of the major options. These alternatives and a number of others will be discussed in more detail in a paper CBO is preparing for the Subcommittees on Oversight and Health of the House Committee on Ways and Means.

Repeal the Separate Deduction for Health Insurance Premiums

One of the simplest possible changes would be to eliminate the itemized deduction for half the first $300 of health insurance premiums. This proposal was approved by the House last year as part of the Revenue Act of 1978, but it was dropped in the House-Senate Conference on the bill. Repealing the separate deduction for half the first $300 of health insurance premiums would simplify the medical expense deduction and reduce current incentives for individuals to obtain health insurance. At 1978 income levels, this change would reduce tax expenditures for health insurance by about $240 million.

One problem with this option is that it would put people who must pay for their own health insurance at a disadvantage relative to those who have their insurance paid for by their employers. Those who buy their own insurance already often pay higher rates for individual policies than they would pay for comparable coverage in a group plan. This tax change would further widen the gap between these two groups.

Limit the Employer's Deduction or the Employee's Exclusion for Health Insurance Payments to a Fixed Dollar Amount

An equally simple but potentially more effective change would be to limit the employer's deduction or the employee's exclusion to a fixed amount per employee. This change would encourage employers to offer and employees to request less-expensive health insurance plans, since additional insurance would have to be purchased with taxable dollars. A dollar limit on the exclusion or deduction might induce employees to join health maintenance organizations (HMOs) or to select insurance policies with cost-sharing provisions. Because HMOs and insurance plans with cost-sharing provisions tend to discourage the use of avoidable medical services, either of these approaches would tend to lower expenditures for medical care.

For the limit on the employer deduction or the employee exclusion to have its maximum effect, it would have to be a fairly tight one. If the limit were set too high, the incentives to choose a low-cost plan would be small. It may also be useful to try to deter employers or employees from buying more insurance with taxable dollars. This is less of a problem if the employee makes the payments, since he or she would at least have a clear appreciation of the cost of the extra coverage. Extra employer

contributions, by contrast, could be provided in ways that are not easily visible to employees.

This option would also be more effective if the limitation were imposed on the employee's exclusion rather than the employer's deduction. Limiting the deduction would not affect employer contributions at government agencies and nonprofit organizations, since these institutions are generally not taxed. Employees at all kinds of establishments, by contrast, would be affected by changes in the employee's exclusion.

Require Firms to Offer a Choice of Health Plans and to Make Equal Contributions to Each

A third option would be to require firms to offer a choice of health insurance plans and to make equal contributions to each. This alternative could be combined with the previous option of limiting the exclusion to a fixed dollar amount. Under this approach employers would be required to offer every employee a choice of health plans, with a ceiling set on all contributions and equal contributions required for each plan.

Like the simpler limitation proposal, this alternative would encourage employees to choose less-expensive health insurance plans. Competition among plans would be more actively fostered, though, because organizations offering low-cost plans would have easier access to employees. Insurers with high-cost plans would then be especially vulnerable to a loss of subscribers. This in turn could induce high-cost insurers to pressure health care providers to keep costs down. Some insurers might also respond by offering plans that limit coverage to a selected group of relatively efficient hospitals and physicians. Both these effects would increase sensitivity to costs on the part of providers. Competition among insurers would be further encouraged if, in addition to offering a choice of plans, the law required that employees who chose plans with premiums below the maximum contribution receive the difference in cash from their employers.

Require All Tax-Subsidized Health Plans to Contain Deductibles and/or Coinsurance Requirements

A fourth change that has been suggested is to require all tax-subsidized health insurance to contain provisions that require consumers to pay a portion of all costs in the form of deductibles or copayments. A version of this idea has

been proposed by Representative Jones, who has introduced a bill that would limit the employer's deduction for health insurance payments to plans with coinsurance rates of 25 percent or more for hospital services. Under the Jones bill, however, no further cost-sharing would be required once a patient's out-of-pocket costs for these items exceeded either $2,000 or 15 percent of annual income, whichever was less.

Cost-sharing may help to reduce medical expenditures, because the demand for medical services is sensitive to the price perceived by the patient. It may be desirable to be somewhat flexible in the type of cost-sharing required, however. Different people may prefer different forms of cost-sharing, and if they are allowed some choice they may be less likely to purchase supplementary coverage that could largely counteract the effects of cost-sharing provisions. In addition, there is still a good deal of uncertainty about the effects of different types of cost-sharing. Deductibles may have a much greater effect than copayment requirements, for example. The effects may also vary with the type of medical treatment involved. The demand for hospital services seems to be less sensitive to price, for example, than does the demand for outpatient care.

The most flexible way to achieve cost-sharing would be to put a ceiling on the employee's exclusion, since any form of cost-sharing would be permissible so long as it reduced premiums to the level of the ceiling. More specific guidelines on cost-sharing could, of course, be provided, while still falling short of locking in a particular requirement.

TAX INCENTIVES FOR HEALTH INSURANCE AND HOSPITAL COST CONTAINMENT

Changing the tax subsidies for private health insurance is a very attractive method for containing medical costs. Other approaches, however, are also available. Among these is the President's proposal for hospital cost containment. Although discussing the merits of the President's proposal is beyond the scope of these hearings, it is important to recognize that hospital cost containment can be a complementary approach toward lowering medical costs, rather than a competing one.

Changes in the tax treatment of health insurance contributions would reduce medical expenditures by providing incentives for employees to choose insurance policies that, in turn, create more incentives to economize on the use of medical services. Such responses would take time, however, and still more time

would be needed for health-care providers to perceive the additional pressures and then respond with changes in practice. Thus, any spending reductions that come from changing the present tax treatment of health insurance are likely to develop very slowly.

Expenditure reductions from hospital cost containment, by contrast, should begin much sooner. Since the legislation would apply to current spending, hospitals would face a revenue constraint at once. There would be some delay before expenditures were cut in response to this constraint, however. Cost containment might also be more effective than tax changes at curbing hospital costs, because the constraint on hospital revenues might be more limiting than market pressures from less extensive health insurance policies. Thus, because cost-containment reduces hospital expenditures in a way different from tax law changes and takes effect more quickly, cost containment should not be seen as an alternative to changing the current tax treatment of health insurance premiums. Instead, the two approaches are complementary and would both serve to limit total medical expenditures.

APPENDIX THE EFFECT OF CATASTROPHIC HEALTH INSURANCE ON TAX SUBSIDIES FOR HEALTH INSURANCE CONTRIBUTIONS

Enacting catastrophic health insurance would not change the incentives provided by current tax provisions to obtain comprehensive health insurance with little or no cost-sharing. It would, however, reduce the attractiveness of buying catastrophic health insurance and affect the amount of tax expenditures generated by the current tax provisions. If catastrophic coverage comes about through mandated employer coverage, employer contributions for health insurance will increase. Thus, revenue losses from the employee's exclusion will rise. If coverage comes about through a government-provided health plan, by contrast, employers who now offer catastrophic coverage could eliminate it from their health plans. In that case, employer contributions would fall and revenue losses would decrease. Current initiatives point toward mandated employer coverage, however, so that catastrophic health insurance will probably result in higher revenue losses from the exclusion.

While catastrophic health insurance seems likely to increase revenue losses from the exclusion, revenue losses from another tax expenditure, the medical expense deduction, would decrease.

Catastrophic health insurance would cover a substantial portion of the out-of-pocket costs for very expensive, uninsured medical care. Thus, out-of-pocket costs for very high medical expenses would decrease, causing the amounts claimed through the medical expense deduction to fall. The decreases from the medical deduction, however, would probably be less than the increases in expenditures from the employee's exclusion, since insurance premiums generally are set above the expected level of benefit payments. Thus, catastrophic health insurance is likely to increase the overall level of tax expenditures for medical care.