



National Association of Health Underwriters

America's Benefits Specialists

The Tax Code and Health Insurance Coverage

A Discussion of Issues Related to Changing the Federal Tax Exclusion

July 2008

Executive Summary

- The federal Tax Code helps to encourage private health insurance coverage in a number of ways, with the largest aspect being the so-called federal “tax exclusion” in employer-sponsored insurance (ESI). The exclusion refers to the amount of an individual’s group health insurance coverage premium paid by an employer, which is not taxable to the employee as income.
- The tax exclusion has helped incentivize nearly two-thirds of the U.S. population under the age of 65 (more than 160 million lives) to be covered by quality private health insurance through the employer setting. ESI has many advantages, including controlled entry into and exit from the program, which ensures the even distribution of risk; federally guaranteed consumer protections like portability rights; the ease of group purchasing and enrollment and the economies of scale of group purchasing power.
- The amount of federal tax subsidy (or foregone revenue) attributable to the income tax exclusion for employer payments for health insurance and health care (for self-insured plans) was approximately \$106 billion for FY 2007 (about three percent of our nearly \$3 trillion annual federal budget outlays).
- Proponents of revamping the current tax exclusion have focused on two criticisms: it is unfair that individuals who happen to work for an employer offering insurance get a tax break while those who seek to purchase insurance elsewhere do not; and due to the subsidy, there is increased demand for health insurance/services, which contributes to higher health care costs for everyone.
- The issue of tax equity/fairness is a shortcoming of current law, but can be addressed with extending tax incentives to those who do not have access to ESI. Overutilization or inappropriate care can be attributable to many factors, but the goal of tax subsidies for health insurance is to make care more accessible and affordable, so induced demand of *insurance*, at some level, is inevitable. But it is important to distinguish that insurance coverage does not necessarily equate to timely and appropriate use of medical care. Any constructive debate over revamping the federal tax treatment of health care must address not only what a new system might seek to accomplish, but also what tradeoffs and unintended consequences might be, and who would be likely to be most affected by any changes.
- Many proposals for changing the tax exclusion would call into question the future role of employers in providing health insurance, as capping or eliminating the exclusion could have significant implications for the composition of large-group risk pools under ESI that have helped make coverage affordable and desirable.
- NAHU agrees that the Tax Code can and should be used to encourage health insurance coverage, and that policymakers should look to build on the successes that ESI has achieved to date.

The Tax Code and Health Insurance Coverage

The National Association of Health Underwriters (NAHU) is the leading professional trade association for health insurance agents and brokers, representing more than 20,000 nationwide. NAHU members service the health insurance policies of millions of Americans and work on a daily basis to help individuals and employers purchase health insurance coverage and make the most out of that coverage. The organization has a unique perspective of the health insurance market place, because its members are intimately familiar with the needs and challenges of health insurance consumers, and have a clear understanding of the economic realities of the health insurance business, including both consumer and employer behavioral responses to public policy changes.

The federal government has a rather long history of involvement in the purchase of health insurance, and through current tax policy, has incentivized nearly two-thirds of the U.S. population under the age of 65 (more than 160 million lives) to be covered by quality private health insurance through the employer setting. For more than 60 years, employer-sponsored insurance (ESI) has helped to effectively pool individual health insurance risks over time and across groups, with remarkably little government interference. NAHU strongly agrees that the Tax Code can and should be used to encourage as many people as possible to be covered by health insurance. It believes that policymakers should look to build upon the successes that our health care delivery system has achieved to date.

NAHU stands for the proposition that all Americans deserve a health care system that delivers both world-class medical care and financial security. Americans deserve a system that is responsible, accessible and affordable. This system should boost the health of our people and of our country's economy. That being said, the system must also be realistic.

The time is right for a solution that controls medical spending and guarantees access to affordable coverage for all Americans. NAHU believes this can be accomplished without limiting peoples' abilities to choose the health plan that best fits their needs and ensures them continued access to the services of independent state-licensed counselors and advocates. It also believes that, given that the vast majority of privately insured Americans receive their health insurance coverage through their employers or the employers of their spouses or parents, the preservation of both the employee federal tax exclusion and the deduction for employers' health care provision costs is critical.

NAHU is at the forefront in developing solutions to current health care challenges by developing a set of recommendations for a stronger health care delivery system. NAHU's ***Healthy Access*** proposal is a comprehensive approach to meeting the country's various challenges of cost, access and quality, and represents a yardstick for evaluating other proposals. Details of ***Healthy Access*** can be found on NAHU's website at:

<http://www.nahu.org/legislative/healthyaccess/index.cfm>.

(Please see Appendix A for a summary)

The federal Tax Code helps to encourage private health insurance coverage in a number of ways, but the largest tenet of the tax policy is the so-called federal “tax exclusion” in ESI. This refers to the amount of an individual’s group health insurance coverage premium paid by an employer, which is entirely excluded from the employee’s income for income and payroll tax purposes. As a result of this tax policy/subsidy/expenditure, the after-tax cost of health insurance is discounted, and job-based insurance can be anywhere from 15% to 50% less expensive than buying coverage individually.¹

Merits of the Tax Exclusion/Employer-Based System

Through the tax subsidy provided to purchase private health insurance in the employer setting, most Americans have access to health plans that are innovative, flexible and efficient. Benefits change with the times, new strategies for cost containment are adopted and re-evaluated, and private employer-based plans are able to bargain very effectively on behalf of their covered populations. For the majority of all Americans under the age of 65, ESI is a reliable and cost-effective method for attaining high quality health insurance coverage. Significant margins of Americans rate their health insurance positively.² And, despite much rhetoric about the erosion of ESI, rates of private employer-sponsored coverage have remained relatively constant, with the proportion of workers having coverage either through their own employer or someone else’s employer averaging between 70 and 74% over the past 15 years.³

Other tax exclusion features of the current Code provide that active employees participating in a Section 125 cafeteria plan may pay their share of premiums on a pre-tax basis through salary reduction. Such salary reduction contributions are treated as employer contributions; thus, they are also excluded from gross income and payroll taxes. Reimbursements under employer plan for medical expenses are also excludable from gross income and wages. There is no limit on the amount of employer-provided health coverage that is excludable.

The IRS definition of “health plan,” for purposes of the exclusion for employer-provided health coverage, applies to more than just traditional health insurance plans. Account-based arrangements commonly used by employers to reimburse medical expenses of their employees (and their spouses and dependents) include health Flexible Spending Accounts (“FSAs”) and Health Reimbursement Arrangements (“HRAs”). Generally, contributions to these accounts are allowed to be made on a pre-tax basis.

One of the main reasons that federal tax policy has encouraged health insurance purchased through one’s employer is that, a group of people working for a company often provides a convenient, stable and efficient risk pool for health insurance. Employer-sponsored health insurance coverage has many advantages, including the controlled entry into the program,

¹ The after-tax discount on the price of health insurance under ESI is roughly equal to an individual’s combined marginal income and payroll tax rates, but additional premium differences between ESI and other non-group products are attributable to the fact that ESI generally is more generous coverage than in the individual market, and ESI is able to mitigate adverse selection through controlled entry into and exit from health insurance plan products. Exclusion from applicable state income tax can also be a factor.

² Kaiser Family Foundation, Health Insurance Survey, October 2004

³ EBRI Issue Brief on “The Future of Employment-Based Health Benefits: Have Employers Reached a Tipping Point?” by Paul Fronstin, No. 312, December 2007

which ensures the even distribution of risk; federally guaranteed consumer protections like portability rights; the ease of group purchasing and enrollment and the economies of scale of group purchasing power. In addition, it is a means for employers to provide equitable contributions for their employees.

Benefits available to group health insurance consumers under ESI are generally much more extensive than those available to consumers spending a similar amount in the individual market. For example, many individual policies substantially limit coverage of items that many group consumers consider to be standard, such as prescription drugs, maternity benefits and mental health benefits. Group health insurance also provides a reliable payment mechanism for millions of Americans, which helps keep costs down and results in many more insured than if individuals were expected to apply separately. These benefits seem to be recognized—at least implicitly—by most of the U.S. adult population. Nearly 70% of American workers receive health coverage through their employers. Take-up rates for ESI are strong at almost 85%, with fewer than five percent of workers eligible for health benefits being uninsured.⁴

Offering health insurance to workers is in employers' interest. Although under no federal legal obligation to offer subsidized health insurance, 99% of large firms (200 or more workers) and more than 83% of firms with 25 or more workers offer health benefits.⁵ Most do so for a somewhat simple reason: a healthy workforce is directly linked to healthy productivity. Thus, employers' ability to offer incentives to differentiate nonwage-related benefits helps them to attract the best workers and remain competitive. The government further supports ESI through the Tax Code by recognizing firms' insurance premiums paid on behalf of their workers as a business cost, which are generally deductible for tax purposes.

The amount of federal tax subsidy (or foregone revenue) attributable to the exclusion for employer payments for health insurance and health care (for self-insured plans) is approximately \$106 billion (about three percent of our nearly \$3 trillion annual federal budget outlays). When one considers that, for this "expenditure," some 160 million lives are helped to be covered by private health insurance, the federal government averages about a \$675 annual subsidy for each covered individual. NAHU maintains that this is a desirable cost-benefit ratio.⁶

⁴ Fronstin, EBRI Issue Brief No. 312, December 2007

⁵ "Employee Health Benefits 2007 Annual Survey," (#7672), The Henry J. Kaiser Family Foundation and Health Research and Educational Trust, September 2006

⁶ Joint Committee on Taxation, "Estimates of Federal Tax Expenditures for Fiscal Years 2007-2011," (JCS-3-7, September 2007). The tax exclusion of amounts of employer-provided health insurance purchased through cafeteria plans is estimated to be an additional \$30 billion per year. Some observers of the tax exclusion point out that its cost to the government is closer to \$200 billion per year, considering foregone Social Security (OASDI) and Medicare (HI) payroll taxes. While this is true, it bears mentioning that the amount of taxable payroll these foregone revenues represent is negligible in terms of both programs' current and future budgetary needs. And in Social Security's case, including employer-paid health care coverage in the Social Security wage base would lead to increased outlays for Social Security benefits in the future that could offset over the long run a significant part of any added payroll tax revenues today. See John Shiels and Randall Haught, "The Cost of Tax-Exempt Benefits in 2004," *Health Affairs Web Exclusives*, February 25, 2004.

Although the employment-based health benefits system reduces transaction costs, may lower premiums for some people who otherwise could not afford health insurance and helps sustain a great percentage of the population with coverage, there are certainly areas where it can be improved to help make it more affordable and accessible. Again, for a further analysis of the systematic issues beyond the Tax Code, NAHU's *Healthy Access* proposal lays out a vision for offering more risk pool options; minimizing mandates; constraining medical costs; and maximizing health care resources, including the extension of tax incentives especially for those outside the employer system.

Despite its merits, the employer-based system is not suited for everyone's health insurance needs. There are obvious problems and questions that would arise were the government to force the employer system on populations that do not naturally belong to it. How do we deal with part-time workers, workers who change jobs frequently, low-wage workers and workers in small firms? These are the workers whose job-based coverage has been eroding the most. It does not make sense to force part-time workers, multiple job holders, or workers in small, unstable businesses to obtain coverage through their jobs. Often, they and their employers will have gone their separate ways before the coverage even becomes effective. In such cases, an employer mandate may be ineffective and, inadvertently, may also become a hidden payroll tax on low-wage workers in small businesses. For individuals in these situations, a more level playing field with tax subsidies in the individual market (in tandem with ESI) merits serious consideration, and would also assist with health insurance portability (see section on pg. 10 "Extending Tax Equity for Health Insurance").

Issues Related to Eliminating or Capping the Tax Exclusion for Some Other Tax Preference

Though well intentioned, proposals to eliminate or cap the current tax exclusion and possibly substitute it with some other tax preference raise significant issues that merit further evaluation. Proponents of eliminating or capping the employer exclusion generally focus on two issues: health insurance affordability and tax equity.

Affordability

In terms of affordability, there are some who believe that third-party payment structures shroud the true cost of health care/insurance and, that combined with the attendant tax exclusion, they remove incentives for the wise use of health care dollars. They contend that overutilization of health services occurs as a result of this dynamic, which contributes to the increase in health care costs for all.

There is an assumption in this line of thinking that workers who are offered a choice of non-taxable employer-paid coverage will select the most expensive health plan available rather than the plan that is the best value for the dollar. There is a further assumption that because of a disconnect between price and product purchasing decisions common with other goods and services, there is induced demand for health services that drives costs higher for everyone.

NAHU certainly agrees that overutilization of health care services is a problem that can have a significant impact on health insurance costs. As is discussed in *Healthy Access*, a national effort to constrain the growth of medical care costs will do more to increase the affordability

of health insurance than any market reforms, because health insurance premiums are directly tied to the cost of medical care. However, the goal of tax subsidies for health care is to make it more accessible and affordable, so induced demand for *insurance*, at some level, is inevitable.

Additionally, it is important not to confuse insurance coverage with the rate and dimensions of medical care utilization. Insurance coverage and the comprehensiveness of benefits do not necessarily equate to consumers utilizing (appropriately or inappropriately) the services of such coverage. In fact, unmet medical needs or delayed care is a phenomenon associated with both the insured and uninsured alike. The number and proportion of Americans (both insured and uninsured) reporting going without or delaying needed medical care has been increasing by some measures (i.e., offsetting evidence of underutilization). According to the Center for Studying Health System Change, one in five Americans (59 million people) reported not getting or delaying needed medical care in 2007, up from one in seven (36 million people) in 2003.⁷ Those reporting either an unmet need or delayed care (again, both insured and uninsured) cited reasons ranging from concern about medical care cost, insurance or provider issues and personal reasons (such as lack of time or procrastination).

There is also considerable evidence that overutilization of health care service can be attributed, at least in part, to provider payment paradigms based on the volume of discrete services rather than episodes of care.⁸ Another continuing problem is the development and exacerbation of health conditions that require more expensive modes of treatment and that could otherwise have been prevented or better managed at the outset. A corollary to this is lack of patient compliance with prescribed regimens for the majority of health care that happens between doctor visits, which also adds to greater use of medical services. According to the Centers for Disease Control and Prevention, chronic diseases such as asthma, cancer, diabetes and heart disease account for more than 75 cents of every dollar we spend on health care in this country.⁹ Although there are no easy solutions to these trends, employers, through their insurance offerings, are helping to lead the way in the delivery of innovation and health care quality initiatives. For example, spending in the employer setting on health promotion, wellness and chronic disease prevention has yielded considerable dividends in reduced health care costs. Programs have achieved a rate of return on investment ranging from \$3 to \$15 for each dollar invested, with savings realized within 12 to 18 months.¹⁰

Moreover, the problems of overutilization of medical care services and the disconnect between most American consumers and the cost of the care they receive is not a problem that is limited to those who have group health insurance coverage. These issues are present in all health insurance markets because all traditional health insurance claims are paid by a third party. In fact, one could argue that overutilization may be more prevalent in the

⁷ Peter Cunningham and Laurie Felland, "Falling Behind: Americans' Access to Medical Care Deteriorates, 2003-2007," Center for Studying Health System Change, Tracking Report No. 19, June 2008

⁸ Karen Davis, "Paying for Care Episodes and Care Coordination," *New England Journal of Medicine*, Volume 356: 1166-1168, March 2007

⁹ Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. Chronic Disease Overview page: <http://www.cdc.gov/nccdphp/overview.htm#2>

¹⁰ David Anderson, Seth Serxner, Daniel Gold, "Conceptual Framework, Critical Questions and Practical Challenges in Conducting Research on the Financial Impact of Worksite Health Promotion," *American Journal of Health Promotion*, May/June 2001, 15(5):281-295

individual market, because individual market consumers are more likely to want to “use” their benefits to justify their direct premium expenditures.

NAHU maintains that a preferable way to help curb excessive utilization and claims, as well as moderate costs by increasing competition among providers, is by providing more transparency and disclosure of health care prices and quality, and by increasing access to consumer-directed health insurance products, both in the individual and group health insurance markets. Our health system would certainly benefit if health insurance consumers in both markets were more aware of the cost and quality of the health care that they are purchasing.

We know that American consumers and patients respond favorably to incentives, and that they are increasingly conscious of health care prices. From the growth of lower cost and more convenient retail clinics, to the increasing trend of medical tourism, we seek out the best deal for the best quality. NAHU strongly encourages health insurance carriers, as well as hospitals, physicians and other health care providers to provide better access to the prices they pay and charge for care to all consumers. NAHU would also support legislative and regulatory efforts at the state and federal levels to require increased transparency, should voluntary efforts fail, provided that such governmental efforts are not overly burdensome.

Curbing excessive utilization and claims can also be achieved through expansion of consumer-directed health insurance plans. While not suitable for everyone, these products provide appropriate financial incentives for enrollees to be more aware of costs, and to use information available on cost and quality in making purchasing decisions. To the extent that consumers have more control over their health care dollars, many believe that they can become more efficient users by delaying or forgoing care that may be of low marginal value.

Tax Equity

Although the goal of tax equity for individual market health insurance buyers is certainly laudable and one that NAHU supports, there are several reasons why removing or capping the tax exclusion to help achieve this may need further evaluation in light of the realities of health insurance markets and the absence of preferable pooling mechanisms in the non-group market.

First, group health insurance rates vary significantly by state and are impacted by a wide variety of factors beyond plan design or comprehensiveness of benefits, including state rating laws and other requirements such as mandates. Health insurance prices are also driven by factors such as geography, industry and the age and health status of participants (i.e., composition of the insured group). Some employers pay higher rates than others, and employees and employers often have no control over the difference in rates they are charged. The price of a high-end plan for employers/employees in one state may be the same price or less than the cost for a much more modest plan for a different employer elsewhere. Thus, under the regime of some cap on the exclusion, individuals could incur additional taxes simply because of the health status of the population of the workers in their pool or because of the geographic region in which they live.

Second, in efforts to discourage employees from seeking so-called “Cadillac plans,” proposals to revamp the tax exclusion implicitly assume that employees have a choice in employer-provided health benefit plans. However, almost one-half of those covered under

ESI have only one plan choice available to them.¹¹ Health plan participation requirements (which can vary significantly by state and health insurance carrier) and factors relating to administrative costs often result in employers only offering their employees one group health benefits plan option. Moreover, employees do not always have a say in the health plan designs offered by their employers. If the employer-sponsored plan available to an individual does not meet the cost parameters of some alternative tax preference, individuals may have little or no tax recourse if they want to keep their group health insurance coverage and all of the consumer protections and benefits associated with it.

Proponents of altering the tax exclusion also often make the point that the current tax policy is regressive, citing that workers in higher tax brackets receive greater tax advantages in dollar amounts than those received by lower-paid workers. This occurs because high-income workers face a higher marginal tax rate, and if employer premium contributions were suddenly counted as income, they would realize a greater tax benefit as compared to lower-paid workers. Proponents often suggest limiting or eliminating the tax exclusion for those of higher means (who presumably would purchase insurance without the exclusion) so that tax subsidies might be retargeted to offer extra help to those of lesser means.

This of course begs the question as to which individuals are considered of higher means. By design, revamping the tax exclusion means that the government would be charged with determining at some level what the appropriate amount of health care is. Drawing appropriate lines on income and equity for health care is no easy task, and is complicated further by the fact that costs can vary significantly in different parts of the country. And although some see the current exclusion as an untapped reservoir of revenue that can help address other needs of our health care system, the American public may be skeptical of having some new regime of health care tax policy be susceptible to the political whims and budgetary picture of the day.

In addition, some observers question whether health care and income are always interchangeable, and point out that the exclusion also contains progressive elements that are often overlooked.

There are a number of reasons why health insurance premium contributions from one's employer might not be considered the same as ordinary income. First, individuals enrolling in an employer's health insurance health plan offering are engaging in socially and economically responsible behavior. It benefits society, and it is not as if they are getting something for nothing. Second, the amount of the benefits offered by employers is generally the same for all workers with the same employer, regardless of income (i.e., there is no correlation to wage-related compensation). Third, as a *percentage of income*, the exclusion may also be viewed as progressive because it represents greater savings for lower-income families than for higher-income families. That is, although the exclusion is greater in dollar amounts for families with higher income, as a percentage, the relative amount of tax savings falls as income rises.¹²

¹¹ Kaiser Family Foundation / HRET Employer Health Benefits 2006 Annual Survey

¹² EBRI Issue Brief on "The Tax Treatment of Health Insurance and Employment-Based Health Benefits" by Paul Fronstin, No. 294, June 2006. See also Institute of Medicine. "Employment and Health Benefits: A Connection at Risk." Washington, DC: National Academy Press, 1993.

Furthermore, it is fairly well documented that individuals tend to prefer employment-based health benefits over taxable wages when given the choice, in part, because of the tax treatment of benefits. When employed Americans with health coverage are asked whether they would prefer \$6,700 in employment-based health insurance coverage or an additional \$6,700 in taxable income, 80% chose the employment-based health coverage. Two-thirds would prefer employment-based coverage to an increase in income even if an employer paid \$10,000 toward the coverage. Furthermore, this preference for employment-based coverage emerges regardless of employees' demographic characteristics.¹³

Although the amount of employer premium contribution is generally the same for all employees in a particular firm, critics point to the fact that its relative value under the exclusion is greater for those higher up the earnings spectrum, and that its value is zero for those who have no income tax liability.

Congress has also faced the issue of perceived tax regression in Social Security's payroll tax. In an effort to lighten the burden on working people below certain incomes, Congress introduced the Earned Income Tax Credit in 1975. That is, extra targeted assistance was provided to qualified workers, while the universality of the Social Security program was maintained. In the health insurance world, the exclusion could be made more equitable and progressive with the addition of a targeted refundable tax credit—which could be paid to the taxpayer even if the amount of the credit exceeds the tax liability and which would result in a reduction in taxes for families with no federal income tax liability.

The Tax Exclusion and Employment-Based Pooling Arrangements

Another important issue for policymakers to consider is the effects that a change in the tax exclusion might have on pooling arrangements for employers, and employers' willingness and ability to continue offering job-based health insurance at preferable large group rates.

In terms of insuring a group of individuals, employment-based groups are often considered “natural groups” in the sense that they were formed for reasons other than the purchase of health insurance. Insurers are more willing to provide insurance for a naturally formed group than for a group that was formed solely for the purpose of buying health insurance because the risks of adverse selection are mitigated. And employers are generally willing and able to offer their insurance on a guarantee issue basis and at community rates, meaning that everyone in the employer group, no matter what age or health status, is offered coverage and charged the same premiums.¹⁴

In a purely voluntary system, such as the American system, the risk of adverse selection is relatively high because those most likely to seek insurance for health care are also those most likely to need health care. As a result, when insuring groups in the employer setting, insurers recognize a generally good mix of insurable risk and know that adverse selection is mitigated because of controlled entry into and exit from the plan by the employer, allowing those individuals the same opportunity to be covered by a health insurance plan. Hence,

¹³ EBRI and Matthew Greenwald & Associates, Inc., 2005 Health Confidence Survey

¹⁴ EBRI Issue Brief on “Health Insurance and Taxes: Can Changing the Tax Treatment of Health Insurance Fix Our Health Care System?” by Paul Fronstin and Dallas Salisbury, No. 309, September 2007. HIPAA requires that insurance sold in the small group market (2-50 employees) also be issued on a guaranteed issue basis.

employment-based health insurance is a potent means for spreading risk among both healthy and unhealthy individuals.¹⁵

Although broadening health insurance choice is generally considered a positive goal, if a change in the tax exclusion is structured in such a way that workers would have a choice to leave the employer group insurance offerings to pursue individual market policies, there could be changes to the pool of the employer's insured population. Younger, healthier workers whose health insurance premiums typically might cost less than their alternative tax preference may shift from employer-sponsored to individual coverage. To the degree this occurs, the employer-based market could become a less healthy mix of insurable risk, as sicker, older workers stay with their employer-based coverage while more of the healthier workers move to the individual market. And the exodus of younger and healthier populations from an employer's pool would likely drive up the costs of the employer plan, for both the employer and beneficiary alike. The likely destabilization of group risk pools that could well result raises the question of whether employers would continue to offer health insurance to their workforce.

Building on the Employer-Based System: Extending Tax Equity for Health Insurance

The issues relating to the Tax Code and health insurance are not unlike those facing Congress in the 1970s when it was looking to expand options for personal retirement savings. Congress did not seek to dismantle a successful employer-based pension system just because all employers did not offer plans. Instead, it created IRAs and other tax-preferred avenues for retirement saving to complement and build upon our ever evolving employer-based pension system.

In a similar vein, why dismantle a successful and essentially popular ESI system and take away employers' incentives to differentiate nonwage-related benefits? As referenced earlier, this is not to say that the employer-based system does not require improvements. But we can fashion tax equity and level the playing field for those outside the employer system in other more targeted, more productive ways. Building on safety net programs, we should use the Tax Code to guarantee that low-income people can afford adequate insurance and that affordable health insurance exists either at work or in a reformed non-group market, without encouraging excessive spending.

ESI need not disconnect consumption decisions from payment responsibilities, nor reduce consumers' incentives to seek out prices and other health information that would facilitate cost-effective decisions. Consumer-directed health insurance options like HSAs, HRAs and FSAs are highly compatible with ESI and are growing in popularity, and NAHU strongly supports enhancing access to these unique health options through tax incentives.

NAHU's membership of more than 20,000 health insurance agents and brokers works every day to help millions of employers and individuals make responsible health insurance purchasing decisions. Our organization is committed on a national level to providing more

¹⁵ *Ibid.*

tools and resources for workers to make more informed decisions about health benefits and health care, and to give people options in terms of purchasing coverage.

We also have organizations like the Leap Frog Group, the Consumer Purchaser and Disclosure Project, the Human Resources Policy Association and the AQA Alliance that are all making significant investments in these areas to help better educate employers and consumers.

ESI is proof that the Tax Code can be used effectively to encourage the purchase of health insurance. Rather than upend the successes of ESI and the current tax exclusion, NAHU believes that tax incentives for the purchase of health insurance should build on what has worked in ESI and be used in tandem with the current employer system.

NAHU supports efforts to help level the playing field in terms of tax incentives for purchasing health coverage. One way would be to adopt targeted tax incentives and regulatory relief for small businesses to better afford health insurance offerings. Under current law, the self-employed health insurance deduction is not considered an ordinary and necessary business expense, as it is for the corporate entity, and thus premiums are still subject to the self-employment (FICA/payroll) tax. A good step in the right direction would be to equalize the self-employed health insurance deduction to the level corporations deduct, by changing it from a deduction to adjusted gross income, to a full deductible business expense on Schedule C.

A refundable, advanceable and assignable individual health care tax credit would give uninsured Americans direct financial assistance with their monthly health insurance premiums, making them more affordable. A refundable credit would ensure that even uninsured people who owe no taxes are eligible for assistance. An advanceable credit would ensure that the uninsured receive the credit when premium payments are due, and not require them to wait until the end of the tax year for reimbursement. An assignable credit would allow the uninsured to have their credit sent directly to an insurer of choice or to their employers if they get coverage through the workplace. This would reduce burdensome accounting paperwork and leave individuals with only the remaining premium balance, if any.

NAHU believes that a refundable tax credit is preferable to a tax deduction. A look at the roster of uninsured individuals today reveals that most are moderate to lower income workers, and nearly half of the uninsured have no income tax liability.¹⁶ Unfortunately, for these individuals, a tax deduction offers little incentive beyond what is already available. Because they do not owe income tax, they do not get a deduction other than the amount they are paying for payroll tax. Although this is helpful, it is unlikely to be enough to enable them to afford health insurance coverage.

Congress might also seek to remove the 7.5% of adjusted gross income limit of medical expenses on tax filers' itemized deduction Schedule A form, and to allow the deduction of individual insurance premiums as a medical expense.

¹⁶ "Health Savings Accounts and High Deductible Health Plans: Are They an Option for Low-Income Families?" (#7568), The Henry J. Kaiser Foundation, October 2006

Tax incentives for the purchase of health insurance outside of the employment-based system in this manner would also help address another common criticism of ESI—namely the perceived lack of portability of one’s health insurance at the end of employment with a firm that offers it. Such tax incentives can also help address what is colloquially referred to as “job lock,” or instances where individuals or families feel they must remain in a less-than-desirable job where one is offered insurance because they could not otherwise afford it.

Policymakers may also want to consider additional reforms to the nonlarge-group market for enhancing the accessibility of insurance with any additional tax incentives. The issue of pre-existing conditions and individual market coverage portability has been repeatedly identified as a problem with our nation’s individual market coverage system. People who have obtained individual coverage when healthy and then acquired a medical condition can be limited in their options for switching coverage plans, due to preexisting condition and medical underwriting requirements. However, these very requirements are what helps prevent individual market adverse selection and keeps individual market prices down for the entire insured population. Texas, for example, addressed this issue a number of years ago in a way that ensures people access to coverage while still preserving affordability in the private market. The state offers individuals who have been responsible and maintained individual market health insurance coverage over time credit for their prior coverage with just a one-month waiting period.

The Road Ahead

Although there are many issues surrounding the Tax Code’s support for expanding access to quality private health insurance, NAHU urges policymakers to preserve and strengthen what has worked for group health insurance under ESI, and to build on that by pursuing creative and equitable remedies to fill our remaining gaps in health care access while preventing new gaps from expanding. A constructive debate over revamping the federal tax treatment of health care must address not only what a new system might seek to accomplish, but also what tradeoffs and unintended consequences might be, and who would be likely to be most affected by any changes.

Far from being some relic of a bygone era, employer-based insurance supported through the current tax exclusion is responsible for many of the innovations in insurance coverage in recent years, with employers directing their insurance carriers to develop and implement many enhancements in the health care arena. This includes wellness and health promotion initiatives, high-performance networks, pay-for-performance, tiered cost sharing for prescription drugs, centers of excellence, value-based benefit designs and HSAs.¹⁷

Providing equitable tax treatment of all health insurance purchasers is a worthy goal that would help foster and facilitate additional innovations and experimentations for expanding insurance coverage on the state and local levels.

¹⁷ Paul B. Ginsburg, “Employment-Based Health Benefits Under Universal Coverage,” *Health Affairs*, Vol. 27, No. 23 (May/June 2008)

The most promising approach involves building on ESI while slowing the growth of overall systematic health care costs. The expansion of consumer-directed health care plans for instance that rely more on tax-advantaged personal saving earmarked for health expenses—both in conjunction with the employer setting and outside of it—can help individuals better assess the cost and quality of the choices they make in health care.

Removal of tax inequities for health insurance would increase the American public's confidence in the operation of competitive markets in health care and private insurance. As NAHU is really at the center of “helping to make health care happen” in America, we stand ready to serve as a resource to policymakers to help answer these important questions so that we can achieve better tax incentives for making private health insurance more affordable and accessible for all Americans.

APPENDIX A: NAHU's HEALTHY ACCESS PROPOSAL

NAHU believes that any sustainable national health system reform should control the growth in medical spending and guarantee access to affordable coverage for all Americans. We maintain this can be accomplished without limiting the people's ability to choose the health plan that best fits their needs and ensures them continued access to the services of independent state-licensed counselors and advocates. NAHU's Healthy Access proposal is a comprehensive approach to meeting this challenge, and a yardstick for evaluating other proposals.

CONSTRAINING MEDICAL COSTS

Comprehensive health reform initiatives need to address the true underlying problem with our existing system: the cost of medical care. We feel that the following recommendations would make important improvements to the U.S. health care system to lower costs, improve quality and create greater efficiency:

Behavior and Lifestyles Recommendations

- Require federal and state governments to incorporate wellness and disease-management programs into medical programs for employees and government-subsidized health coverage.
- Provide employers with legal protections and tax and premium incentives for wellness programs.

System Inefficiencies Recommendations

- Provide incentives for doctors and medical facilities to improve system efficiencies and eliminate errors with pay for performance, best-practice guidelines and support for evidence-based medicine.
- Create federal standards for interoperable electronic medical record technology to help unify the health care system, reduce errors and improve patient satisfaction.
- Enact comprehensive medical malpractice reform that limits non-economic damage awards, allocates damages in proportion to degree of fault, places reasonable limits on punitive damages and attorney fees, and imposes reasonable statutes of limitations on claims. Encourage state authorities to increase the effectiveness of discipline imposed on incompetent doctors.

Cost-Shifting Recommendations

- Reimburse providers participating in all federal health care coverage programs, including Medicaid, Medicare and SCHIP, at the same level paid to providers serving federal employees through the Federal Employees Health Benefit Plan.
- Encourage states to streamline the application processes for public health insurance programs like Medicaid and SCHIP, and allow for presumptive eligibility, so that all eligible participants are enrolled and their providers are paid instead of incurring uncompensated care expenses

Decreasing Utilization Recommendations

- Encourage expansion of consumer-directed health insurance products.
- Make consumers fully aware of the cost of the health care that they are purchasing by enabling and encouraging health plans and providers to overcome policy concerns (e.g., prohibiting gag provisions in provider contracts) and bring complete price information to the public as soon as possible.

ACCESS FOR ALL

All Americans should have access to affordable health care coverage. As important as affordability, however, is choice. There needs to be choice of providers, choice of payers and choice of benefits, with many price and coverage options. The reality is that we are a diverse nation with diverse needs. One size does not fit all when it comes to health care.

Guaranteed Access to Health Insurance Coverage in Every State Recommendations:

- Right now, in a number of states there are people with serious medical conditions and no access to employer-sponsored health insurance; they cannot buy health insurance at any price. Most states, but not all, have independently established at least one mandatory guaranteed purchasing option, the most common and effective of which is a high-risk health insurance pool. The federal government should

require that all states have at least one private guaranteed purchasing option for all individual health insurance market consumers.

- The federal government should provide seed grants to states creating high-risk pools and states that provide risk-pool premium subsidies to low-income citizens and older beneficiaries (who tend to be charged the highest rates) to help ensure continued coverage for early retirees.

Reinsurance Recommendation:

- Making it easier and more affordable for carriers to reinsure expenses related to extraordinary claims could prove to be an effective way of lowering premiums. In considering reinsurance as part of an overall reform package, Congress should conduct a study to thoroughly analyze the efficacy of reinsurance programs.

Affordable Access Grants to States Recommendations:

- States should be encouraged to create regulatory climates that ensure the availability of many affordable coverage options, and should offer premium subsidies to targeted populations in need of such support. The federal government should make block grants available to states to encourage and reward health insurance innovations that utilize the strengths of the existing private marketplace.

Tax Equity Recommendations:

- The vast majority of privately insured Americans receive their health insurance coverage through their employer or the employer of their spouse or parent. The preservation of the federal employer tax deduction and employee exclusion is critical.
- But the employer-sponsored health insurance system does not work for everyone. As such, federal tax laws should be updated to provide the same tax deductions to individuals and the self-employed that corporations have for providing health insurance coverage for their employees.
- Congress should remove the 7.5 percent of adjusted gross limit of medical expenses on tax filers' itemized deduction Schedule A form, allow the deduction of individual insurance premiums as a medical expense, and equalize the self-employed health insurance deduction to the level corporations deduct by changing it from a deduction to adjusted gross income to a full deductible business expense on Schedule C.
- The federal requirements regarding individual policies sold on a list-bill basis -- whereby the employer agrees to payroll-withhold individual health insurance premiums on behalf of its employees and send the premium payments to the insurance carrier but does not contribute to the cost of the premiums -- need to be clarified regarding the establishment of Section 125 plans, HIPAA group insurance protections, and the applicability of state-based individual health insurance laws and regulations.

Public/Private Producer Community Education Partnership Recommendations

- All health insurance consumers, both private and public, should have access to quality information and assistance regarding their health care coverage. NAHU will assume responsibility for training insurance agents in all coverage options, both public and private, through the creation of a designation program—the Certified Health Care Access Advisor.

FINANCING ACCESS

Many of the Healthy Access recommendations, particularly those concerning controlling our nation's rising health care costs, will actually save both state and federal health care dollars. Despite these substantial savings, eliminating public-program cost-shifting and ensuring access to affordable private health insurance will likely result in the need for increased public funds. NAHU feels such funds should generally be derived from assessments on activities that drive health costs higher. Assessments that encourage healthy and cost-effective behaviors while discouraging unhealthy and cost-ineffective ones will result in both additional funds and healthier citizens.