1. Tax treatment of health insurance premiums
2. Pooling and a “public” plan

Bryan Dowd, Ph.D.
Division of Health Policy and Management
School of Public Health
University of Minnesota
June 17, 2009

Tax Exemption of Health Insurance Premiums

Currently, health insurance premiums “paid by” the employer are exempt from federal and state personal income taxes and FICA taxes.

(The employer’s share, like wages, also is exempt from corporate taxation as a cost of doing business, but only a few people are talking about changing that.)

The employee’s out-of-pocket premiums also are tax exempt under Section 125 of the Internal Revenue Code (as is out-of-pocket spending on approved types of medical care).

An aside

Most health economists would say that the employer doesn't pay any part of the health insurance premium. Employees' total compensation is based on what they're worth in the market, and total compensation includes the cost of their health insurance, life insurance, vacation, sick pay, etc. If one item goes down, another will go up and vice versa.

An aside

So why do employers care about the cost of health insurance if they don’t pay for it?

Because employees’ satisfaction with their total compensation package depends on *characteristics* of health insurance, not its cost.

If an employer can offer the same health plan characteristics at lower cost they can increase employee wages and gain an advantage in the labor market.

Tax expenditures

Tax exemptions are referred to in budget analyses as tax expenditures. They represent the tax revenue foregone by the government from allowing specific activities to tax exempt (e.g., home mortgage interest, health insurance premiums and out-of-pocket payments, etc.).

So how much foregone revenue are we talking about?

Federal Tax Expenditures

Tax Expenditure	**FY 2008 revenue effect (billions $)**	**FY 2008 to FY 2012 estimated revenue effect (billions $)**
Exclusion of employer contributions for medical insurance premiums and medical care	$160.19	$1,005.98
Deductibility of mortgage interest on owner-occupied homes	89.43	520.26
Accelerated depreciation of machinery and equipment (normal tax method)	64.67	421.79
Capital gains (except agriculture, timber, iron ore and coal)	51.96	251.88
Employer pension plans	48.48	229.35
Deductibility of charitable contributions other than education and health	45.76	265.31

Source: Office of Management and Budget: *Analytical Perspectives: Budget of the United States Government – Fiscal Year 2008* (2007). Note: The OMB calculation of tax expenditures for employer contribution does *not* include foregone FICA payroll tax revenue, also due to the tax exclusion for ESI.

Minnesota Tax Expenditures

State General Fund

Year	**2008**	**2009**	**2010**	**2011**
Contributions by Employers for Medical Insurance Premiums and Medical Care (Established in 1933)	$812,200,000	$878,400,000	$945,300,000	$1,008,800,000
Section 125 cafeteria plans -- not all health insurance (Established in 1975)	$230,000,000	$251,900,000	$275,900,000	$302,100,000

Plus the exemption for long-term care insurance. Source: *State of Minnesota Tax Expenditure Budget: Fiscal Years 2008-2011* Minnesota Department of Revenue, Tax Research Division. http://www.taxes.state.mn.us.

Tax Expenditure Estimates

<u>These numbers may be too high for two reasons</u>:

1. They assume no response to making tax-exempt goods and services taxable. Doing so probably would cause consumption of those goods and services to drop.
2. Making expenditures on a commodity tax exempt also can reduce the competitiveness of the market for that commodity. Economists often overlook this effect because they assume markets are competitive and prices are equal for equal products. Dowd, et al. (2001) showed that the price elasticity of health plan choice was reduced when consumers could pay their *out-of-pocket* premiums with pre-tax dollars.

How should we think about tax expenditures?

Some criticize treating tax exemptions as "expenditures" because they think that language presumes that all revenue belongs to the government.

Some criticize calling tax exemptions "subsidies" because they think nothing should be taxed.

But if we're going to have *any* government activity, why favor some types of activities over others?

Effects of tax expenditures

Allowing some goods and services to be tax exempt, e.g., purchased with pre-tax income makes them cheaper (in terms of hours worked) than goods and services purchased with post-tax income.

In that sense, tax exemption represents a *relative* subsidy of the price of the tax exempt goods and services.

People consume more of the commodity than they would if they purchased it with post-tax dollars, and price differentials between competing products are compressed, making the market less competitive.

So who benefits?

The sellers of the tax-exempt goods and services.

How is the foregone tax revenue distributed?

In a progressive tax structure, the “tax break” inevitably confers greater benefits on those in higher tax brackets.

Federal Income Tax Rates

Rate	Married Joint		Married Separate	
	More than …	But not more than …	More than …	But not more than …
10 percent	$0	$16,700	$0	$8,350
15 percent	$16,700	$67,900	$8,350	$33,950
25 percent	$67,900	$137,050	$33,950	$68,525
28 percent	$137,050	$208,850	$68,525	$104,425
33 percent	$208,850	$372,950	$104,425	$186,475
35 percent	$372,950	Above	$186,475	above

Minnesota State Income Tax Rates

Rate	Married Joint		Married Separate	
	More than …	But not more than …	More than …	But not more than …
5.35 percent	$0	$33,220	$0	$16,610
7.05 percent	$33,220	$131,970	$16,610	$65,990
7.85 percent	$131,970		$65,990	

So who benefits?

Exempting a $5,000 individual coverage policy from Federal taxes saves an individual in the 15% tax bracket $750, and a person in the 35% tax bracket $1,750. The exemption thus is regressive.

Sheils and Haught (*Health Affairs*, February 25, 2004) estimated that the current tax exemption of premiums allocated over 70 percent of the 2004 tax expenditure to families with incomes over $50,000 per year, about 50 percent of all families in 2004 (U.S. Census Bureau, 2007a).

And who pays?

Foregone tax revenue must be offset by lower government spending or higher tax rates.

Chamberlain and Prante (*Tax Foundation*, 2007) found that the benefits of government spending are distributed disproportionately to the poor, so cutting those services would increase the regressivity estimates.

But if the foregone revenue is offset by increasing progressive taxes, then the regressivity estimates would be reduced.

A few novel ideas

If we think we're spending too much on health care, why are we subsidizing the purchase of health insurance? (When in a hole, …)

But if the government wants to help people buy health insurance, why not offer the same level of help to everyone?

Converting the exemption to a credit

The federal tax expenditure on health insurance works out to about $840 per person in 2004, or roughly about $1,100 in 2007.

5.2 Million Minnesotans in 2007 and roughly $800 million in foregone tax revenue. That's about $150 per Minnesotan.

The amount of the credit

So converting the current tax exemption into an **advanceable, refundable** tax credit would give each Minnesotan $1,250 cash towards the purchase of health insurance. (Family of four = $5,000)

For a single person in a15% federal and 5.35% Minnesota tax bracket and a $5,000 policy, their government assistance *rises* from $1,017.50 to $1,250.

For a single person in a 35% federal and 7.85% Minnesota tax bracket, their government assistance *falls* from $2,142 to $1,250.

The amount of the credit

For a person paying no taxes and not otherwise enrolled in publicly-assisted health insurance, their amount of government assistance increases from $0 to $1,250.

Important note: This is not a proposal to raise money or cover a deficit. It would be a good idea under any circumstances.

Possible objections

1. It won't help poor people much.

   Response: It will help them more than now and distribute the government's help more equitably.

2. Employers might drop health insurance.

   Response: Employment is the best pooling mechanism at work in the health insurance market today, and also results in lower marketing and underwriting costs. If it can't survive with those advantages on a level tax playing field, then so be it.

Recent history

1. Health economists have been proposing this change for 40 years.
2. McCain proposed it during the 2008 campaign and was vilified by Obama.
3. Obama needs $1.6 trillion to fund health care reform. Eliminating itemized deductions (charity) has encountered opposition within his own party.
4. Sometimes we do the right thing for the wrong reason.

Second topic:
Portable, long-term risk protection (LTRP) and a "public" plan

The goal:

To give people in the individual and small-group insurance market:

1. Long-term protection against having their risk redefined if they get a serious illness.
2. Geographically portable.
3. Allows a choice of health plans during open enrollment

Who are these people?

Self-employed

Spouses of Medicare beneficiaries who are not eligible for Medicare.

Early voluntary/forced retirees

Young people between jobs

Employees of small groups

Current protections in Minnesota

1. Guaranteed issue for small employers
2. HIPAA protects transitions from group insurance to the individual market
3. Guaranteed renewability, but…

There no choice of plans (or market areas) after you get sick, and

Insurers can drop lines of business.

Protections I *don't* need

A. Long-term premium protection against *risk* redefinition …
   - Does *not* necessarily imply full community rating.
   - For example, I don't need premium protection against aging.

B. … that is portable (within the U.S.)
   - Does *not* imply protection against geographic variation in costs, types of plans, or availability of providers in one market versus another.

Good News and Bad News

<u>The good news</u> :

I have all those protections now (even geographic portability within the state) as long as I continue to work for the University of Minnesota.

<u>The bad news</u> :

I might lose my job, or want to become self-employed. In that case, if I have cancer, I'm reliant on HIPAA protection for the transition to the individual market, but after that, I'm locked in, despite the fact that I have been paying community-rated premiums for nearly 30 years. Bad for me, and probably bad for the economy.

What LTRP requires of me

<u>Exactly what I do now as a University employee</u>:

- Maintain continuous enrollment in the pool whether I'm healthy or sick, and thus ...

- Be willing to subsidize random illness events in others, even if the consequences for them are long-term, and I remain healthy.

- But attempts at pooling in the individual and small group market have not been terribly successful. (A somewhat controversial point.)

A Pressing Problem

In my opinion, the failure of the private health insurance industry to offer this product is the most compelling rationale for a national "public" health insurance plan and the source of most horror stories (or tied with claims denials for first place).

Better than silly arguments for a national public plan:

1. It is needed to keep private plans' costs low.
2. It is needed to keep private plans honest.

Not an Easy Task: The MEIP Pool

Minnesota established a pool for small groups (2 or more employees) in 1992. It offered LTRP. **It closed in 1997. Why?**

1. Possibly because the policies were too generous and thus too expensive.

2. Possibly because out-of-pool sales picked off the healthy groups.

3. Possibly because of insurance reforms in the small group market.

The usual story about failed pools

- Everyone enters the pool at an actuarially fair premium. Equal risks pay equal premiums.
- In the “second period,” some people get sick and others don’t.
- The healthy are quoted a lower “second-period” experience-rated premium than the community-rated pool premium, and they leave the pool.
- Long-term risk protection evaporates.
- Horror stories ensue. Is anything wrong with this story?

Is there a public policy problem?

Maybe there are structural barriers (e.g., antitrust or restrictions on cross-state insurance sales) or maybe people:

1. Don't understand the choices that they have? (LIKELY)

2. Understand the choices, but act irrationally? (POSSIBLY, BUT A DEAD-END FOR ECONOMICS.)

3. Understand the choices and act rationally (i.e., they're risk preferring)? (MAYBE, BUT IF SO, THEN THERE SHOULDN'T BE REGRET.)

Are we talking about temporally-limited rationality?

Policy options

1. If the problem is misunderstanding the options, the answer would be better consumer information campaigns.

2. If the problem is irrationality that leads to substantial regret, perhaps there is a role for paternalism. I hope not.

3. If there is temporally-limited rationality (Stop me before I accept an experience-rated premium again!) then the problem gets interesting.

The key ingredient for LTRP: “Glue”

The great advantage of employment-based insurance is that people generally are unwilling to change jobs in order to get a lower health insurance premium. (“Job lock” is the opposite: Unwillingness to change jobs because you might get a *higher* health insurance premium.)

Note: If we do away with employer-based insurance we will need another source of glue. Individual mandate/entitlement?

Potential sources of “glue” in the individual and small group health insurance market.

1. A minimum length of pool enrollment.

The Public Employees Insurance Pool (PEIP) in Minnesota requires a two year commitment and has been stable for nearly 20 years. But those are small government units.

Potential sources of “glue”

2. Non-refundable prepayment of additional premiums to encourage continued participation.

<u>A penalty assessed at the time of exit</u>.

Pauly, Mark V., Kunreuther, Howard and Richard Hirth. "Guaranteed Renewability in Insurance," *Journal of Risk and Uncertainty* 10 (1995) 143-156.

Potential sources of “glue”

3. Loss of risk protection upon exit from the pool – reassessment of risk if the person or group attempts to re-enter the pool.

<u>A penalty assessed at the time of attempted re-entry</u>.

Potential sources of “glue”

4. A late enrollment penalty – A penalty assessed at the time of first, delayed, entry.

Example: Part D’s late enrollment penalty for Medicare beneficiaries without creditable coverage.

A pool could install *all* these incentives.

Another proposal

Freestanding “health status” insurance policies that pay the premium increase due to deteriorating health status. Insurers can experience-rate all their enrollees. Subsidies are required for those already sick.

Cochrane, John H. "Time-Consistent Health Insurance," *Journal of Political Economy* 103:3 (1995) 445-473.

Cochrane, John H. “Health Status Insurance: How Markets Can Provide Health Security,” *Cato Institute: Policy Analysis, number 633* (February 18, 2009).

A LTRP Pool

Can we offer a stable state-level LTRP pool for people in the individual and small group market?

Some suggested steps:

1. Establish a bare bones benefit package that people with modest incomes can afford. That will mean exempting that coverage from all state mandated benefits. That will be the LTRP product. (MN already working on that.)

A LTRP Pool

2. Risk-rate people when they enter the LTRP pool, or if they drop out and try to re-enter.

Healthy people will pay less than people who already are sick. There is no such thing as long-term risk protection against getting cancer for people who already have cancer. If we don't want people with cancer to pay higher premiums we will have to subsidize their premiums. Such subsidies should be income based. Poor healthy people should not be asked to subsidize the premiums of rich sick people.

A LTRP Pool

3. Allow premiums in the LTRP pool to vary by age and by market area, but not by health status.

4. Allow any insurer to sell this policy in the LTRP pool, but allow a public plan to sell it, too.

5. Have open enrollment periods that allow free plan switching within the pool with no medical underwriting once a year.

6. If necessary, risk-adjust premiums across all plans in the pool.

A LTRP Pool

7. If an insurer ever drops out of the LTRP pool they will be charged whatever it takes to move their enrollees to another plan in the pool. Private insurers will have to maintain capital reserves that cover that potential penalty. The equivalent cost will have to be reflected in the public plan's premium in order to maintain a level playing field.

8. Encourage inter-state agreements for open-enrollment transfers.

A LTRP Pool

9. A national public plan is likely to prosper in that environment because it might be the only plan that allows true geographic portability without plan switching in any part of the U.S.