Prologue: The favorable tax treatment of employer-provided health insurance has had the very beneficial effect of motivating the rapid growth of private insurance coverage. Data from the National Health Care Expenditures Study estimated that by 1977, 88.3 percent of employees in the United States worked for employers that offered health insurance plans. But the cost of this tax incentive, which is most generous to employed upper-income people, has escalated by many billions during a period when the federal government has squeezed medical spending for the old and poor. These foregone tax revenues now represent the federal government's second largest health program, as the administration's 1986 spending estimates document: Medicare $73 billion; tax expenditures $24 billion; Medicaid $24 billion; veterans medical care system $9 billion; and the National Institutes of Health $5.5 billion. In this essay, Professor Alain Enthoven of the Stanford University Graduate School of Business puts forward a sharply higher estimate of the revenue loss that will result from this favorable tax treatment and then explains why. Enthoven, an economist by training, has provided much of the intellectual lifeblood for the movement toward the use of market principles in health care delivery. But, interestingly, his relationship to the Reagan administration, which believes fervently in market approaches, has been, at best, arms length. For the better part of a decade, Enthoven has been promoting comprehensive medical care delivery reform through the marriage of two ideas: (1) the creation of a network of competitive medical plans which would operate under economic incentives that encourage efficiency and (2) the development of a regulatory framework that insures the operation of these plans on a basis which comports with the best interests of society. The administration has embraced the first idea, but considered the second to be in conflict with its determination to deregulate government. The administration supports the placement of a ceiling on the deductibility of employer contributions to employee health benefits, but the tax revision bill recently approved by the House Ways and Means Committee retains the exemption.
The federal budget for fiscal year 1986 estimates the “tax expenditure” (tax revenue loss) from exclusion of employer contributions for medical insurance and medical care from the taxable incomes of employees at $23.7 billion. The likely revenue loss will be about twice that.

Three developments lead to this conclusion. First, while the official definition of “tax expenditures” refers only to income tax revenue losses, and not payroll tax revenue losses, there will still be payroll tax losses which, if the Treasury’s income tax revenue loss estimates were correct, would be about $10.2 billion.

Second, the Health Care Financing Administration has recently increased the previously estimated volume of private health insurance by about 18 percent. The previous estimates did not adequately reflect the large growth in employer “self-funded” insurance plans, many of which are “self-administered” or managed by third-party administrators and not reported by insurance companies. This change was published in December 1984. It is apparent, and not surprising, that the Treasury’s figures, published in February 1985, do not reflect this.

And third, a very important event took place in May 1984, when the IRS clarified the status of “cafeteria plans” including “salary reduction” and “flexible spending arrangements” under Section 125 of the Internal Revenue code. According to the IRS ruling, employees may have their health insurance premium contributions paid with pretax dollars by making salary reduction agreements with their employers, or by setting up flexible spending accounts (FSAs). FSAs can be used to tax shelter employee premium contributions and out-of-pocket medical expenses. According to the IRS ruling, the amount in the FSA must be specified in advance and cannot be changed during the tax year. And the account must be “forfeitable” or on a “use or lose it basis,” that is, the unused amount at the end of the year, if any, cannot be returned to the employee.

Flexible Spending Accounts

Salary reduction or FSAs are an ideal device for employees to use to tax shelter their health insurance premium contributions. The administration of such a payroll deduction is very simple. The premium contribution is predictable, so the “use it or lose it” restriction is no constraint at all. The employer has strong incentives to offer it. For one, he can avoid the employer’s share of payroll tax on the sheltered amount. Moreover, use of this procedure breaks the link between the payment that is characterized as “employer contribution” and the tax break, making it easier for the employer to limit the growth in his contribution without denying the tax break to his employees.

Policymakers in Washington are only beginning to appreciate the po-
This ruling creates for tax sheltering premiums and out-of-pocket expenses. For example, federal employees must pay their premium contributions with net-after-tax dollars. The federal government may well continue to deny its employees the opportunity to tax shelter their contributions through “salary reduction” or FSAs. But the spouse of a federal employee working in the private sector may pay his or her spouse’s premium contribution through an FSA set up with the private employer. One can only guess at the speed with which use of this device will spread, but it seems reasonable to suppose that within the next year or two, the great majority of employers and employees will be using it at least to tax shelter health insurance premium payments. So the figures I will present here are estimates of the potential loss, assuming that people take advantage of an easy tax break. The actual loss may take a little longer to catch up.

Before the IRS ruling, it was normal to estimate or assume that about 80 percent of the premiums of employer-sponsored insurance was paid by the employer, hence tax sheltered, while about 20 percent was paid by the employee out of net-after-tax income. If 90 percent of employee contributions are sheltered this way, 98-percent of premiums in employer-sponsored insurance will be tax sheltered. This would raise the amount of revenue lost to the federal budget by 22.5 percent. Adding the $10.2 billion payroll tax loss to the $23.7 billion income tax loss, and increasing the total successively by 18 and 22.5 percent, one obtains a revised estimate of $49 billion of revenue loss in 1986.

The revenue the Treasury will lose through tax sheltering of employer contributions to health insurance can be estimated directly. The total volume of private health insurance premiums in 1983 has recently been estimated at $110.5 billion. The president’s budget forecasts 1986 gross national product (GNP) at 30 percent above that of 1983. For many years, health spending and health insurance have grown faster than the GNP. However, the growth of employer cost containment, competitive medical plans, and Medicare prospective payment are having an impact. Growth with the GNP would seem a reasonable basis for a forecast. That would put 1986 premium volume at about $144 billion.

**Tax sheltering through employment.** Most, but not all of this, can be tax sheltered through employment. But there is uncertainty and some disagreement over certain categories. In making their estimate of revenue loss, federal officials assume that about 82 percent of the aggregate premiums can be tax sheltered. This produces a very conservative estimate, and, in my view, a substantial underestimate. Most of the remainder is in “individual” coverages, that is, contracts directly between the insurer and the insured individual, and coverages through “association groups.” Examples of the latter are state bar associations, Granges, associations of realtors, accountants, and the self-employed. To be sure, a self-
employed person in the IRS definition of the term may not tax shelter his or her health insurance premium except as an itemized deduction to the extent that it is a part of medical expenses that exceed 5 percent of adjusted gross income. So it is easy to understand how one might assume that many independent professionals and small business people cannot tax shelter their premiums. However, many of the people insured through association groups are employees, such as associates and secretaries in law firms.

There are at least four ways in which a self-employed professional or business person might tax shelter health insurance premiums and out-of-pocket expenses through FSAs. The first is to incorporate, as many have done. The second is to form an employment relationship with a client and have the “employer” pay the premium in lieu of cash. The third is to put one’s spouse on the payroll as an employee, and to pay his or her family coverage. The fourth is to obtain coverage through one’s spouse’s employment. All four of these practices exist today. The new IRS interpretation of Section 125 increases the incentive to use one or another of them. I believe it is likely that most of the people covered through association groups and a substantial number of those covered through individual policies soon will have tax sheltered their premiums if they have not already done so, and that at least 90 percent of total premium volume is susceptible to tax sheltering, possibly more.

Official federal estimates of revenue lost are based on a marginal income tax rate for the average taxpayer in 1986 of 25 percent, and a combined income and payroll tax rate of 33.34 percent. But a Congressional Budget Office (CBO) study showed that most of the tax-free dollars go to households with incomes above the average, suggesting that a higher marginal tax rate such as 36 percent is applicable. These figures yield potential revenue loss estimates that range from about $39 billion to $47 billion for 1986.

Estimating the potential revenue loss from the use of FSAs to shelter out-of-pocket expenses is inevitably much more speculative than estimating the revenue loss from tax sheltering premiums because there is so little experience with the former. The administrative costs are higher and the procedures are more complicated than for sheltering premium contributions. But the FSA for out-of-pocket expenses, even of the “forfeiting” variety, opens up very large potential revenue losses to the Treasury. It is reasonable to suppose that given a little time to get used to the idea and a normal amount of American ingenuity, many regularly employed Americans, especially those in higher tax brackets, will figure out how to get much of their health care spending paid for with pretax dollars via FSAs. The “forfeiting” restriction is likely to end up being much less restrictive than appears at first glance.

Consider the opportunity as seen by the employed head of household.
Let us say it is December and he or she must direct the employer to reduce his or her salary by a specified amount for the coming year and put that into a medical FSA. The employee estimates the family's needs. First, if this year's FSA is exhausted, how many bills can be delayed until next year, perhaps by delaying completion of a course of treatment? Next, many expenditures can be planned for the coming year. Most surgery is elective with respect to timing. Cosmetic surgery not normally covered by insurance can be planned and included in the FSA. Also, coinsurance and deductibles can be paid out of the FSA, as can glasses, hearing aids, and drugs. In considering the dangers of overestimating, the taxpayer knows that if the end of the year is approaching, he can decide to accelerate payments to some providers or start some elective treatments earlier (for example, have the children's eyes examined and buy new glasses.) There may develop a market for "health insurance" policies for which you pay in December which cover you for 90 percent of the premium amount until the account is exhausted. Underestimates can be compensated by delaying payment or services to the next year. The IRS will disallow some of the maneuvers if it can find them. For example, it will doubtless say that expenses must be incurred in the year in which they are deducted. But the problem of enforcement will be formidable.

A study team in the Department of Health and Human Services recently estimated that the annual revenue losses associated with the sheltering of out-of-pocket expenses through the forfeiting FSAs will grow to $7 billion (in 1983 dollars) over the next several years. This was based on a detailed analysis that seems as reasonable as any under the circumstances. So we are facing total potential revenue losses in 1986 of the order of $46 to $54 billion.

**Imbalances In Present System**

While Congress struggles to cut a few hundred million dollars of spending from Medicare and Medicaid, it ignores a gaping loophole on the revenue side. The Congress and the IRS have created this loophole without setting prior limits on its cost, either per person or in aggregate, and even without knowledge of what it would cost. Yet the cost to the budget of this item will soon rival Medicare!

This illustrates a very great imbalance in the treatment of expenditure items and revenues or "tax expenditures." Politically, the tax break is counted as "tax reduction." It reduces tax revenue as a percent of GNP. Explicit subsidies for the purchase of health insurance count as outlays. Thus, converting from a "tax expenditure" to "on budget" expenditures of the same amount would raise reported taxes and spending as a percent of GNP, though the effect on the deficit would be the same. Indeed, if the explicit expenditures were in fixed dollar amounts, their effect in
distorting resource allocation would be far less than the effect of the present system of tax subsidies. If all employer contributions were included in taxable incomes, and the government subsidized private health insurance through explicit budget outlays, one can be sure that subsidies of this magnitude, distributed in this manner, would never have been enacted.

Why do we have such a tax break? The real reason is historical accident combined with political power of the main beneficiaries. The Internal Revenue Code of 1954 ratified a practice that had grown up during World War II when employer contributions to health insurance and other fringe benefits were exempted from wartime wage controls. They were also excluded from taxable incomes. It would be hard to believe that anyone in 1954 had any idea of the eventual consequences for the health care economy or the budget of excluding employer contributions to health insurance from taxable incomes. But once such a tax break has been granted, powerful vested interests grow up in support of it, and it becomes extremely difficult to change.

Those who defend this tax break do so with the argument that the incentive that it provides to insure is necessary to ensure widespread medical care coverage. Given a choice between cash and medical care coverage without a tax subsidy, young or healthier people and those with low incomes would often choose cash over insurance. This would lead to a process called “adverse selection” in which the healthy would drop coverage, and the cost for all those who retain coverage would be raised. This in turn would cause more people with below-average expected medical expenses to drop out, raising the premiums still further, in a cycle that would eventually destroy health insurance altogether.

Indeed, just such a process is a major contributor to the fact that roughly 30 million Americans, largely those who do not belong to a regular employment group, are without any medical care coverage today. A powerful incentive is needed to make coverage attractive to the healthy so that they will insure and help hold down premium costs for the rest.

As a description of the consequences of a lack of incentives for the healthy to insure, this argument is accurate and persuasive. The trouble is, there is a gross mismatch between this rationale and our actual tax policy. In actual fact, the tax incentives are targeted on the wrong people. The tax incentives are most generous to employed upper income people. In fact, because of our progressive tax system, the higher the income, the greater is the tax subsidy to a person’s health insurance. Because they have incomes and assets to protect, one can be sure most high-income employed people would buy health insurance even if there were no tax subsidies.

On the other hand, the tax subsidies are small or nonexistent for many people who need help the most: the part-time employed, the intermittently employed, the self-employed, the unemployed, and those employed in
marginal industries whose employers do not provide health insurance, and the widows and divorcees who lost their health insurance when they lost their husbands. If these people can get health insurance at all, as well as having to pay for it with higher individual premium rates, many of them have to pay for it with net-after-tax income. These are people whose decisions whether or not to buy health insurance are influenced by its cost. If one believes that federal tax policy ought to be used to promote the spread of private health insurance, then these are the people on whom the tax incentives should be targeted.

A study by CBO estimated that in 1983, 88 percent of tax-free employer contributions went to households with annual incomes over $20,000. The median household income that year was $20,885. The tax benefit averaged $622 per household in the $50,000-$100,000 income range, but $83 per household in the $10,000-$15,000 range.

In addition to giving upper income households more powerful incentives to insure, because they are open-ended, the tax subsidies reinforce the cost-increasing incentives in the health care financing and delivery system. They reduce the marginal cost to the employee of each extra dollar’s worth of health insurance and thereby induce employment groups to buy cost unconscious open-ended comprehensive insurance. The tax system tells upper income groups that if they decide on still more costly benefits, government will pay 40 to 50 percent of the extra cost.

The present tax treatment of health insurance has been one of the main causes of the paradoxical situation that millions of people are overinsured and causing inflation in health care, while millions of other people are underinsured or have no coverage at all. The irony and irrationality of this is compounded by the fact that through the open-ended tax subsidy, the government is subsidizing the efforts of people with above average incomes to bid up the prices and standards of care that the uninsured must then pay for directly and that the government must pay for through Medicare and Medicaid. Government is subsidizing its own competition for resources!

**Changing The Incentives**

These considerations suggest that the social policy goals of incentives and subsidies for medical care coverage ought to be stated more precisely. And the actual tax policy should be tailored to match the goals. As a statement of goals, I would recommend that we seek to motivate and help everyone, whether employed or not, to purchase a good quality comprehensive cost-effective health plan, and to discourage people from purchasing an inefficient overly costly health plan. The policy that would fit this goal would be to subsidize everyone’s purchase of health care coverage up to a limit judged to correspond to the price of a good quality
cost-effective plan, and not to subsidize choice above that limit.

This is not a radical new idea in 1985. Important steps in this direction have been embodied in legislative proposals by some of the most thoughtful and fiscally responsible members of Congress for at least the past six years. In July 1979, Sen. David Durenberger (R-MN), now chairman of the Health Subcommittee of the Senate Committee on Finance, introduced the Health Incentives Reform Act of 1979 which would have, among other things, limited tax-free employer contributions to an amount equal to the average HMO premium. Subsequent versions of that bill set a specific dollar limit, indexed to inflation. Also in 1979, former Rep. Al Ullman (D-OR), then chairman of the Ways and Means Committee, introduced the Health Cost Restraint Act of 1979, which would have, among other things, limited tax-free employer contributions to $120 per family per month, indexed to the consumer price index. In June 1980, Rep. James Jones (D-OK), subsequently chairman of the House Budget Committee, introduced the Consumer Health Expenses Control Act which would have, among other things, limited tax-free employer contributions to $100 per family. In March of 1983, Sen. Robert Dole (R-KS), then chairman of the Finance Committee, introduced his Health Cost Containment Tax Act of 1983 with a 1984 limit on tax-free employer contributions of $70 per month for individual coverage and $175 per month for family coverage, again indexed to the consumer price index. This approach was supported for several years by the Reagan administration and was included in the Treasury's first tax reform proposal in December 1984.

These tax cap proposals would have saved the budget billions of dollars and would have greatly improved the economic rationality of the financial incentives in the health care system. But by themselves they would have done nothing for the self-employed and others without tax-free employer contributions. This year Senator Durenberger introduced S.1211, the Health Equity and Fairness Act of 1985, which contained some very substantial improvements over previous tax cap proposals. While this bill put a limit on tax-free employer contributions of $100 per month for individual coverage and $250 per month for family coverage, indexed to the GNP deflator, it extended the same deduction to individuals, so that, for example, those who do not have tax-free employer contributions could receive the same tax incentive to insure.

As I pointed out earlier, the people who need the most incentive and help with the purchase of health insurance are those with low incomes. People with high incomes have incentives to insure because they have incomes and assets to protect. The trouble with the deduction or exclusion approach is that it is worth more to people in higher tax brackets, much less to people in low brackets.

Therefore, I believe that the Congress ought to go beyond the ap-
The approach of these bills and create a refundable tax credit or direct subsidy to qualified health plans equal, for example, to 40 percent of premium payments up to a limit on subsidized premiums of $60 per month for an individual, $120 for a couple, and $180 for a family in 1986, indexed to GNP per capita. Such a credit would be equally valuable to a person with a low income as to a person with a high income. It would give everyone an incentive to buy a health plan up to the subsidized limit, but would make them fully cost conscious above that limit. (The credit would replace the exclusion.\textsuperscript{10}) Such a subsidy could also be of considerable assistance to state and local governments in their efforts to arrange insurance for the uninsured.

Excluding Medicare and Medicaid beneficiaries who are subsidized separately, these credits, if fully used, would cost the budget about $47 billion in 1986. Over the long run their cost would grow with the GNP, not faster. And the cost consciousness this restructuring would foster would ease the problems of cost growth in Medicare and Medicaid. Thus, the favorable impact on the federal budget would be substantial, including a savings of as much as $7 billion in the first year.

This reform would represent a long step toward universal health insurance. Additional steps to make subsidized insurance available to low-income people would be needed, but this could be done in the context of a competitive, economically rational, and decentralized private market.

If we cannot match our tax policy to the stated objective of promoting widespread health insurance by providing subsidies to low-income people and those without employer-paid health insurance at least equal to those provided to upper income people, then Congress should abolish the tax subsidy altogether, and divide the savings between reducing the budget deficit and giving explicit subsidies to purchases of health insurance by low-income people. Our health care economy would perform better with no tax subsidies to health insurance than with the mismatched subsidies now costing the budget so much.
NOTES

1. Budget of the United States Government, FY 1986, Special Analysis G (Washington, D.C., 1985), p. G46. The Treasury's figure is for the fiscal year. My estimates are for the calendar year. The difference is within the margin of error of all these estimates.


4. Arnett and Trapnell, “Private Health Insurance.”

5. Paul B. Ginsburg, “Containing Medical Care Costs Through Market Forces” (Washington, D.C.: Congressional Budget Office, May 1982). In this study, the “average taxpayer” was in the 33.4 percent combined marginal bracket, but because of the distribution of employer contributions, the applicable weighted average marginal tax rate for these payments was 37.6 percent.


8. Ginsburg, “Containing Medical Care Costs.” This number is implicit in the data in Table 2, p. 27.


10. For more detail, see Alain C. Enthoven. “A New Proposal to Reform the Tax Treatment of Health Insurance,” Health Affairs (Spring 1984).