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Federal Health Care Reform
A Snapshot of Financing Options

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Federal health care reform is currently being debated in Washington, DC, and most of the public discussion addresses health policy issues. Concerns include how we will reform the current system and how to best achieve coverage for all Americans. These discussions largely ignore the question of how the country will pay for such reform. Yet, the success of any reform will be dependent on the investments made in the new system. This brief summarizes key options under discussion and provides a time line for Congressional action.

To achieve the goal of providing universal coverage, policy recommendations must be fully funded. If they are not, reform is likely to fail. Without adequate financing, policy makers will be forced to cut corners: they will have to limit coverage to selected groups or for various services. Those types of limits are likely to disproportionately affect low and middle income and special needs populations and they will undermine successful reform from the start.

The White House announced on June 1st that they will require health reform to be deficit neural. This will require Congress to find 100 percent of the funding necessary for proposed policy reforms. It is not clear whether Congress is willing to commit to this level of support.

In April and May, the Senate Finance Committee held three roundtable discussions on health care reform that included various financing proposals. As the federal budget moves through Congress this summer, assuring that it includes adequate funding support is critical to meaningful health care reform.

Key options for financing the health care delivery system include:

Limiting the Tax Exclusion for Employer Sponsored Insurance. During World War II, frozen wages made it difficult for companies to hire the necessary help from a smaller labor pool. To offset the unintended effect of the wage freeze, the National War Labor Board permitted companies to offer additional benefits, like health insurance, as a non-taxable form of compensation. Today, that exclusion is the largest single subsidy in the tax code. [1] Because it is not counted as taxable income, this exception reduces federal tax collections. In 2007, this policy reduced income and payroll taxes by $246 billion per year.

This policy provides the greatest benefit to those with the highest incomes. Almost half of the benefits of the exclusion went to tax filers with incomes over $75,000. Tax filers with incomes under $20,000 received only 6 percent of the benefit. [2] Giving the most tax deduction to those with higher incomes makes little sense as public policy.

It also encourages spending on the subsidized item. The exclusion encourages businesses to offer, and consumers to accept, more generous or costly coverage than they might normally purchase. This increases demand for care and contributes to rising health care costs.

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[1] U.S. Census Bureau, "Income, Poverty, and Health Insurance Coverage in the United States: 2007", August 2008, Publication P60-235.

[2] Van de Water, Paul, "Limiting the Tax Exclusion for Employer-Sponsored Insurance Can Help Pay for Health Reform", Center on Budget and Poliy Priorities, June 2, 2009.

A cap on this exclusion would make the policy more equitable. That could be done by setting a limit based on the value of the insurance, or based on the taxpayer's income, or some combination of both.

While the exclusion does encourage employer-sponsored insurance, it can be reformed without weakening coverage by employers. Several factors in overall reform would support employer-sponsored insurance as an attractive option for consumers. Employer sponsored coverage is documented to have increased with the individual mandate implemented as part of health reform in Massachusetts. Requiring employers over a certain size to offer coverage would also discourage them from dropping this benefit in favor of the public system. Further, the cap itself could be designed to recognize situations where cost of insurance is particularly high (certain geographic areas, older/sicker workers, unusually high administrative costs) and adjust the limit accordingly.

Curtailing Flexible Spending Accounts (FSAs)). Like the exclusion of employer-sponsored health care, these subsidies are poorly targeted and change consumer behavior. As public policy, they encourage spending on non-essential services and products, particularly at the end of the plan year. They are regressive and yield only modest tax savings, even for wealthier participants. There will be little reason for FSAs if health care reform is sound. Should people chose to continue this option, a limit on annual contributions should be set, either at a fixed amount or based on taxpayer income.

Limiting Health Savings Accounts (HSAs) These accounts also provide greater benefit to the wealthiest tax payers. In some cases, they have been used as a way to shelter money from IRA contribution and income limits. The addition of contribution caps, as well as broader penalties for non-health-related withdrawals would limit their use as tax shelters.

Changes in Medicare and Medicaid. Some savings can be achieved by improving payment and delivery systems in Medicare and Medicaid. Significant savings could come from eliminating overpayments to providers in the Medicare Advantage program. Bundling payments for episodes of illness and reducing hospital readmission rates would create savings in both Medicare and Medicaid. Other proposals could generate additional savings.

Changes in Prescription Drug Programs. Several changes in prescription drug coverage could generate savings. These include increasing minimum rebates and applying those rebates to managed care programs. Both options were approved in the Senate in 2005. Other proposals suggest changes in calculations that adjust rebates for inflation and encouraging states to better manage prescription drug costs. Beneficiaries eligible for both Medicare and Medicaid coverage (dual eligibles) currently receive drug coverage under the Medicare program, where prescription discounts are lower than those offered through Medicaid. By paying through Medicaid instead, the federal government could save an estimated $86 billion over 10 years.

Changes in the tax code. Our current tax code allows a deduction for medical costs exceeding 7.5 percent of adjusted gross income as protection against catastrophic health care costs. If national health care reform is adequate, this provision should no longer be needed. The President has also proposed a limit on itemized deductions for high income taxpayers. Alternatively, some have proposed a surtax on very high income households.

Increase on various "sin taxes". In general, the public shows more support for raising "sin taxes" than any other type of tax increase. Public support for raising the tax on alcohol is particularly high, at 68 percent.[3] Any adjustment of these taxes should include an index for future inflation. There is also discussion about imposing a new tax on high-sugar soft drinks. The current model is Arkansas' volume-based tax, imposed on manufactures, importers and exporters.

[3] Ibed.

Tentative time line of expected action

In the Senate: The Senate Health, Education, Labor & Pensions Committee *tentatively scheduled hearings for June 10-11, with mark-up of the bill the week of June 22.*

The Senate Finance Committee has not released a schedule, but expects *mark-up to begin the week of June 22.*

In the House: The three Committees considering health care reform expect *a joint bill to emerge in mid-June. Hearings and mark-up will follow in late June and mark-up is expected to begin in mid-July.*

Both the Senate and House promise floor action in July. The President wants a law by October 1.

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