Center on Budget and Policy Priorities

820 First Street NE, Suite 510
Washington, DC 20002

Tel: 202-408-1080
Fax: 202-408-1056

center@cbpp.org
www.cbpp.org

Special Series: Health Reform Issues

November 19, 2009

SENATE HEALTH REFORM BILL IS FISCALLY RESPONSIBLE

By Chuck Marr, Paul Van de Water, Edwin Park, and Kris Cox

The health reform bill that Senate leaders unveiled yesterday meets two rigorous fiscal tests: it reduces deficits over the next decade and beyond, and it puts long-term downward pressure on health care costs.

The bill would reduce deficits by an estimated $130 billion over the 2010-2019 period and by about one-quarter of one percent of GDP in the decade thereafter, according to the Congressional Budget Office (CBO). This amounts to about $55 billion in 2020 and several hundred billion dollars over the 2020-2029 period. The bill also would likely slow the growth of health care costs over time by, for instance, imposing an excise tax on high-cost health insurance plans, reducing overpayments that private insurers receive through Medicare Advantage, and reducing the cost of prescription drugs in Medicaid.

Moreover, while the bill extends health coverage to 31 million more Americans, it keeps the total federal cost for all health care spending and tax subsidies in the decade after 2019 essentially where it would be under current law, according to CBO. That's because the bill finances its expanded health coverage by redirecting existing spending and tax subsidies, mainly from less productive uses elsewhere in the health sector.

All of this represents a stark and welcome change from the treatment of major tax and spending initiatives for nearly a decade. Congress enacted, for instance, the 2001 and 2003 tax cuts and the Medicare prescription drug benefit without offsetting costs that totaled in the trillions of dollars. By contrast, the Senate health reform bill would expand coverage while reducing deficits over both the short and long term.

Establishing an Excise Tax on High-Cost Insurance Plans

The federal government provides Americans with more than $250 billion each year in health care subsidies by excluding the value of employer-sponsored health care from individuals' taxable income. These subsidies are the largest for high-income individuals who are enrolled in the most expensive health plans.

For example, managing directors of the investment bank Goldman Sachs receive an average of $40,543 in employer-provided health insurance annually. If this compensation were treated as ordinary income, the federal government would collect $14,777 per director in taxes on it. By *not* treating it as ordinary income, the federal government effectively pays more than a third of these executives' health care premiums. Middle-income people with generous employer-sponsored plans also receive significant tax subsidies (though not as large as higher-income people, since they are in lower tax brackets). Middle-income people who lack employer-provided coverage receive no tax subsidy today.

The Senate bill, recognizing that it is unwise to direct the largest health care subsidies to the people who least need help affording coverage, seeks to reform the subsidy structure. To help pay for health subsidies for low- and middle-income people who now lack them, it would impose a 40-percent excise tax on the value of health plans in excess of $8,500 for singles and $23,000 for families, starting in 2013. (In comparison, the tax thresholds in the bill reported by the Senate Finance Committee were $8,000 and $21,000, respectively.) In the 17 states with the nation's highest health insurance premiums, the thresholds would be 20 percent, 10 percent, and 5 percent higher than these national thresholds for the first three years, respectively. The excise tax would be levied on a non-deductible basis on insurance companies or insurance administrators; it would apply to plans sold in the group market and to self-insured plans, but not to plans purchased in the individual market.

The vast majority of plans would be unaffected by the tax, since the dollar thresholds listed above far exceed the value of most plans. We estimate that in 2013, more than *90 percent* of family plans will have premiums below $23,000. A plan costing $23,000 would be about 40 percent more generous than the plan that most Members of Congress have.[1] Plans that cover retired people over the age of 55 and people in high-risk professions would have still higher thresholds. (High-risk professions include law enforcement, firefighting, rescue/ambulance squads, construction, mining, agriculture, forestry, and fishing.) The thresholds for such plans would be raised by $1,350 (to $9,850) for individual coverage and by $3,000 (to $26,000) for family coverage.

Congressional Budget Office Director Douglas Elmendorf has indicated that limiting the favorable tax treatment of health insurance could help slow the increase in health care costs.[2] The proposed excise tax would discourage insurers from offering, and firms from purchasing, extremely generous health insurance coverage that encourages excess health care utilization. That, in turn, would reduce incentives for excessive health care spending.

The congressional Joint Committee on Taxation projects that most affected employers will modify their health plans to avoid the excise tax and will convert what they had been spending for health coverage in excess of the tax thresholds into higher wages and salaries. Based on an earlier version of the proposal, MIT economist Jonathan Gruber has estimated that the excise tax will increase workers' wages by some $300 billion over the next decade. Under the new Senate bill, the

[1] Paul N. Van de Water, "Excise Tax on Very High-Cost Health Plans Is a Sound Element of Health Reform," Center on Budget and Policy Priorities, November 10, 2009.

[2] Douglas W. Elmendorf, Letter to the Honorable Kent Conrad, June 16, 2009.

increase in wages is likely to exceed $200 billion. Almost two-thirds of those wage gains will accrue to families with incomes below $100,000.[3]

Increasing Medicare Payroll Tax on High-Wage Earners

Currently, workers and employers each pay a flat 1.45 percent on wages to help fund the Medicare Hospital Insurance program (Medicare Part A). The Senate bill would increase the tax rate on high-income employees by one-half of a percentage point to 1.95 percent for that portion of a taxpayer's wage or salary income that exceeds $250,000 for a couple and $200,000 for an individual. This would raise $54 billion over ten years. While this provision would not put downward pressure on health costs like the excise tax discussed above, it does have two notable attributes:

- It would target those best able to pay. The proposal is likely to affect only those in the top 5 percent of the income distribution, a group that has prospered in recent decades. Between 1979 and 2006 (the most recent year for which data are available), the before-tax income of the top 5 percent of households increased by an average of 143 percent (after adjusting for inflation), compared to an average increase of just 15 percent for families in the middle fifth of the income spectrum.[4]

- Raising the Medicare payroll tax also would extend the life of Medicare's Hospital Insurance trust fund. Under current law, the HI trust fund is projected to become insolvent in 2017. In combination with the other Medicare changes in the pending legislation, this proposal would likely push back the date of insolvency by at least four to five years.

Limiting Flexible Spending Accounts

Flexible spending accounts (FSAs) allow employees to pay out-of-pocket health care costs with pre-tax dollars.[5] Employees elect to have a set amount deducted from each paycheck to be deposited in their FSA — free of any income or payroll tax — from which they are reimbursed for out-of-pocket health care costs they incur during the year. FSAs, however, suffer from significant flaws:[6]

- **FSAs encourage excess utilization of health care.** Funds in an FSA can be used to purchase nearly any health care service or item, regardless of whether it is medically necessary, cost effective, or of meaningful health value. In effect, FSAs encourage non-essential health care

---

[3] Jonathan Gruber, "Implications of the JCT Score of the High-Cost Insurance Tax," November 5, 2009, **http://econ-www.mit.edu/files/4845**.

[4] Paul N. Van de Water, "Increasing Medicare Tax on High-Wage Earners Could Help Pay for Health Reform and Strengthen Medicare's Finances," Center on Budget and Policy Priorities, November 13, 2009.

[5] A separate kind of FSA enables employees to pay *child care* costs with pre-tax dollars. This paper focuses solely on FSAs that are used to pay out-of-pocket health care costs. Child care FSAs are not affected by the new Senate health reform proposal.

[6] For more details see Chuck Marr and Kris Cox, "Curbing Flexible Spending Accounts Could Help Pay for Health Care Reform," Center on Budget and Policy Priorities, June 10, 2009.

spending and subsidize purchases of questionable priority.

- **FSAs' "use or lose it" requirement promotes wasteful spending.** Employees must spend all of their annual FSA contributions by March 15 of the following year or forfeit any remaining balance. For many FSA participants, therefore, the approach of March 15 sets off a scramble to use up any funds in their accounts. As one consumer education website proclaims, "If you have an FSA, spend that money!"[7] Another advises, "if you have FSA money to burn, humidifiers generally count as an FSA purchase."[8]

- **FSAs complicate people's lives while providing only modest benefits for non-wealthy accountholders.** People with high incomes benefit disproportionately from FSAs because they are in higher tax brackets, tend to consume more health care, and can afford to deposit larger amounts in their accounts. Middle- and lower-income people benefit much less.

  For example, someone in the 15 percent income tax bracket who contributes $1,380 a year to an FSA (the average contribution for accountholders in 2008) would save approximately $313 in federal income and payroll taxes.[9] Moreover, to receive even this modest benefit, accountholders must keep track of receipts throughout the year and spend all of their FSA contributions before the funds expire.[10] It also should be noted that the $1,380 average contribution figure is pushed up by the large contributions from upper-income individuals; the typical middle-income individual likely contributes less than that and thus receives smaller tax savings.

The Senate bill takes modest steps toward addressing these problems by modifying FSA rules in two positive respects.

First, it would place a $2,500 annual contribution limit on FSAs; under current law no limit exists, although employers are free to set their own. As noted, the average FSA contribution is $1,380, and most middle-income individuals probably contribute less than that.

Second, it would narrow FSAs' overly broad definition of allowable expenses.[11] Under current law, for example, participants can use their FSA dollars to purchase cold medicines, antacids, motion sickness pills, cough drops, band-aids, thermometers, allergy medicines, and rubbing alcohol, among other items. The Senate bill would bring the FSA definition of allowable medical expenses more in line with the definition used for the tax code's itemized deduction for medical expenses, though it would permit the use of FSA funds to purchase over-the-counter drugs with a prescription.

---

[7] "FSA, HSA, HRA, RRA...What's It All Mean?" http://www.planforyourhealth.com/family/allmean/.

[8] "Do you need to spend FSA money?" November 2008, http://frugaldrmom.blogspot.com/2008/11/do-you-need-to-spend-fsa-money.html.

[9] See Janemarie Mulvey, "Health Care Flexible Spending Accounts," Congressional Research Service, November 6, 2009.

[10] Employees must spend all of their annual FSA contributions by March 15 of the following year or forfeit any remaining balance. Aetna reported that 14 percent of its accountholders — one of every seven — failed to spend all of their balances in 2007 and lost an average of $723.

[11] In addition to FSAs, this definitional change applies to health savings accounts (HSAs) and health reimbursement accounts (HRAs).

Community Living Assistance Services and Supports (CLASS)

The Senate health reform bill, like the House-passed bill, includes a new program to help cover the costs of long-term supports and services for people with disabilities. The program would be strictly voluntary and would be funded by the premiums that beneficiaries would pay. Initially proposed by the late Senator Edward M. Kennedy, the program — known as Community Living Assistance Services and Supports, or CLASS — would provide a daily cash benefit to insured individuals who become limited in several activities of daily living. The cash benefit could be used to help the beneficiary continue working and living in the community or to defray part of the cost of institutional care, if that becomes necessary.

The proposal requires the Secretary of Health and Human Services to design the benefits and set the premiums so that the program will be self-supporting from premiums and interest over a 75-year period. The Congressional Budget Office has estimated that an initial average premium of $123 a month would be sufficient to pay for an average benefit of $75 a day while assuring long-run actuarial soundness. By its very nature, a premium-financed program such as CLASS reduces the federal budget deficit in its early years, when many people are paying premiums and few have become eligible for benefits. The Senate leadership, however, is *not* relying on the savings from premiums in the new program's early years as a way to help finance the short-run costs of health reform. CLASS would begin to add slightly to the deficit after 2029, as benefit payments modestly exceeded premiums, but CBO has determined that this effect would be small and that the health reform legislation as a whole — including this provision — would modestly reduce deficits in future decades.

Limiting the Itemized Deduction for Medical Expenses

The itemized deduction for medical expenses allows tax filers with large health expenses to reduce their income tax liability. Individuals with health expenses greater than 7.5 percent of their adjusted gross income (AGI) can claim a tax deduction equal to the portion of their expenses above the 7.5 percent threshold if they itemize their deductions. The deduction provides a greater benefit to higher-income taxpayers since they fall in higher tax brackets than middle-income taxpayers.

To help pay for provisions that would make health coverage more affordable, the new Senate bill would raise the threshold to 10 percent of AGI. This change would target the tax deduction towards people with the highest costs. However, filers over age 65 would remain eligible to deduct expenses in excess of 7.5 percent of their income until 2017.

Discouraging Use of Health Savings Accounts for Non-Health Spending

Health Savings Accounts (HSAs) are tax-favored savings accounts attached to high-deductible health insurance plans. Individuals can make pre-tax contributions to HSAs (as can their employers, if the individual is enrolled in a job-based high-deductible plan). Earnings on HSAs grow tax-free and can be withdrawn tax-free for allowable health-related expenses (e.g., for deductibles, co-payments, and health care items and services that insurance doesn't cover). HSA funds also can be used for other (i.e., non-health-related) purposes but are subject to income tax and a 10 percent withdrawal penalty. At age 65, however, funds can be withdrawn for *any* purpose without a penalty, although withdrawals for payments other than health expenses are taxable.

HSAs offer unprecedented tax sheltering opportunities, in part because — unlike with other tax-favored accounts — contributions, earnings that accrue on the account balances, and health-related withdrawals all are tax-free. The bill would moderate the abuse of HSAs as tax shelters by increasing the withdrawal penalty for funds used for non-health-related purposes to 20 percent.

(Policymakers could go further and subject funds used for non-health-related purposes to a penalty regardless of the age of the accountholder. This step would increase the consistency of HSA rules and equalize the treatment of all withdrawals used for purposes other than health care. It also would have a greater effect in reducing the use of HSAs as a legal way to shelter additional retirement income from taxation.)

Charging Fees to the Health Industry

Health care reform is likely to significantly increase revenues and lower costs for various sub-sectors of the health industry. For example, health insurers are likely to get millions of new customers if health reform achieves near-universal coverage. Drug and device makers should see demand for their products increase; the uninsured tend to forgo needed care due to cost, and greater availability of coverage would allow the previously uninsured to access the medications and devices that treat their conditions or illnesses.

The new Senate bill would require several elements of the health industry — health insurers, pharmaceutical manufacturers, and medical device makers — to pay annual fees starting in 2010 based on an individual firm's market share. The bill, in effect, recaptures a portion of the windfalls that health reforms provide to the health industry by levying these fees. The legislation also would impose a 5 percent excise tax on cosmetic surgery procedures.

Instituting Efficiencies in Medicare and Medicaid

The bill would also take a number of steps that would make Medicare and Medicaid more efficient, which would produce significant savings to help offset the cost of the package.

For example, it would rein in the overpayments that private insurers now receive through the Medicare Advantage program. Medicare Advantage provides health care coverage to Medicare beneficiaries through private health plans as an alternative to the traditional Medicare fee-for-service program. But even though private plans were brought into Medicare ostensibly to introduce competition and reduce costs, the Medicare Payment Advisory Commission (MedPAC) estimates that in 2009, Medicare will pay the private plans 14 percent more per beneficiary, on average, than it would cost to cover these beneficiaries in traditional Medicare.[12] A Commonwealth Fund study estimates that these overpayments exceed $1,100, on average, for each beneficiary enrolled in a private Medicare Advantage plan.[13] The overpayments also increase premiums for beneficiaries in

[12] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy," March 2009.

[13] Brian Biles, Jonah Pozen, and Stuart Guterman, "The Continuing Cost of Privatization: Extra Payments to Medicare Advantage Plans Jump to $11.4 Billion in 2009," The Commonwealth Fund, May 4, 2009.

traditional Medicare by $86 a year for a couple and weaken Medicare's finances by advancing by 17 months the date when the Medicare Hospital Insurance Trust Fund will become insolvent.[14]

MedPAC has recommended for a number of years that Congress eliminate these excessive payments so that Medicare pays the private plans no more than it would cost to treat the beneficiaries under traditional Medicare. The Senate bill would adopt a proposal from the Administration's fiscal year 2010 budget that would reform how plans are paid through the use of a competitive bidding system that would have the effect of significantly scaling back the overpayments over time. Specifically, payment levels for private plans would no longer be set in law but instead would be based on the average of competing bids that plans submit each year to offer Medicare Advantage coverage. (The savings from this provision, while substantial, would be significantly less than those resulting from the provision in the House health reform bill that would eliminate the overpayments to Medicare Advantage plans entirely over three years.)

The package also would improve the delivery of medical care by providing payment incentives in Medicare for hospitals, physicians, and other providers to furnish higher quality care at lower cost to beneficiaries. For example, MedPAC has found that nearly 18 percent of hospital admissions among Medicare beneficiaries in 2005 occurred within 30 days after the individual was discharged from the hospital. MedPAC also found that some of these readmissions could have been prevented if hospitals had provided better care during the initial stay or better follow-up care after the patient was discharged. Preventable readmissions thus raise Medicare costs.[15] The bill would reduce Medicare payments to hospitals with high readmission rates to encourage them to do a better job of preventing avoidable readmissions.

The bill would also lower the cost of prescription drugs in *Medicaid*. Under federal law, as a condition of Medicaid coverage of their products, drug manufacturers must pay rebates to the federal and state governments for prescription drugs that Medicaid dispenses to beneficiaries. These rebates effectively lower the price that Medicaid pays for prescription drugs and ensure that state Medicaid programs pay no more than private purchasers for the same drugs.

The bill would increase the minimum rebates that pharmaceutical companies must pay to Medicaid for brand-name and generic drugs prescribed for Medicaid beneficiaries. These rebate levels have remained unchanged since the mid-1990s. This would reduce federal and state Medicaid costs without harming beneficiaries.

The bill also would extend the Medicaid drug rebates to drugs dispensed to beneficiaries enrolled in Medicaid managed care plans. Currently drugs provided through managed care plans are exempt from the rebate. Congress based this exception on the assumption that managed care plans could negotiate discounted drug prices as favorable as those required under the Medicaid drug rebate. Evidence shows, however, that this likely is not the case and that managed care plans may be paying an average of 11 percent more for drugs than fee-for-service Medicaid does. Requiring manufacturers to pay rebates for drugs provided through managed care plans would ensure that

---

[14] Rick Foster, "Letter to Pete Stark on Medicare Advantage and the Hospital Insurance Trust Fund Solvency," Centers for Medicare and Medicaid Services, Office of the Actuary, June 25, 2009.

[15] Medicare Payment Advisory Commission, "Report to Congress: Promoting Greater Efficiency in Medicare," June 2007.

Medicaid is obtaining the best prices for all of the drugs it covers. Finally, the bill would eliminate a loophole under which manufacturers can make slight alterations to their drugs and present them as new medications in order to avoid paying higher rebates if their drug prices rise faster than inflation.[16]

Conclusion

Compared to a decade in which the costs of major fiscal policy decisions, such as the 2001 and 2003 tax cuts and the Medicare prescription drug benefit, were largely ignored, the pending health reform legislation represents a stark and welcome change. Two rigorous fiscal tests have been established and agreed upon by key players: the legislation must be paid for and must put long-term downward pressure on health care costs. The new Senate bill meets both of these tests.

The legislation would reduce budget deficits by $130 billion over the first ten years and by about one-quarter of one percent of GDP thereafter, according to CBO. Through a more efficient allocation of health resources, the legislation would achieve an historic policy advance – expanding health insurance to an additional 31 million Americans – while keeping the federal government's total health care costs essentially the same in the decade after 2019 as it would be under current policies.

[16] See Edwin Park, January Angeles, and Sarah Lueck, "Reducing Medicaid and Medicare Drug Costs Could Help Pay for Health Reform," Center on Budget and Policy Priorities, June 11, 2009.