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SENATE FINANCE COMMITTEE HEALTH REFORM BILL IS FISCALLY RESPONSIBLE

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

A fundamental principle of the bill that the Senate Finance Committee approved today is that it is budget neutral — that is, its costs are fully offset. It pays for the costs of expanding health coverage to the uninsured by redirecting spending and tax subsidies from less productive uses elsewhere in the health sector.

Several of the offsets are likely to help slow the rate of growth of health care costs over time. For example, the bill would impose an excise tax on insurance company offerings of high-cost plans, limit tax subsidies provided to flexible spending accounts, eliminate the overpayments that private insurers receive through the Medicare Advantage program, and reduce the cost of prescription drugs in Medicaid.

Policymakers should consider including additional offsets as well, which would enable them to strengthen the subsidies designed to help low- and moderate-income Americans comply with the bill's mandate that they obtain health coverage. The subsidies in the current bill would likely prove insufficient to make coverage affordable for a number of low- and moderate-income people with incomes modestly above the poverty level.[1] If, on the other hand, policymakers *scale back* the proposed offsets (some of which are bound to draw criticism from interests that benefit from current health subsidies that are inefficient), that would likely force policymakers also to scale back the assistance for low- and moderate-income people, making coverage still less affordable for them under the new system.

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

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[1] January Angeles and Judy Solomon, "Finance Committee Health Reform Bill Makes Improvements, But Still Falls Short of What Is Needed for Many People to Afford Health Care," Center on Budget and Policy Priorities, October 13, 2009.

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 Finance Committee 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 $8,000 for singles and $21,000 for families, starting in 2013.[2] This 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, fully *90 percent* of family plans will have premiums below $21,000. A plan costing $21,000 would be about one-third more generous than the plan that most Members of Congress have.[3]

In addition, the Finance Committee significantly improved the original excise tax proposal in response to concerns raised by several committee members:

- *Higher thresholds*. Under the revised proposal, plans that cover retired people over the age of 55 and people in high-risk professions would have 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 $1,850 (to $9,850) for individual coverage and by $5,000 (to $26,000) for family coverage.

- *Increased inflation factor*. Under the original proposal, the thresholds would increase annually with the rate of change in the consumer price index (CPI). Under the current proposal, the thresholds would increase with the CPI *plus one percentage point*. For example, if consumer prices rose 3 percent in a given year, the thresholds would be increased by 4 percent.

Congressional Budget Office Director Douglas Elmendorf has indicated that limiting the favorable tax treatment of health insurance could also help slow the increase in health care costs.[4]

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[2] For the 17 states with the nation's highest health insurance premiums, the thresholds would be 20 percent, 10 percent, and 5 percent higher than the national thresholds for the first three years, respectively.

[3] Paul N. Van de Water, "An Excise Tax on Insurers Offering High-Cost Plans Can Help Pay for Health Reform: Would Also Help Slow Growth in Health Costs," Center on Budget and Policy Priorities, August 7, 2009.

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

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.

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 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 $1,208 a year to an FSA (the average contribution for accountholders in 2006) would save approximately $274 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

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[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 Finance Committee 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.

[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 Bob Lyke and Julie Whittaker, "Tax Benefits for Health Insurance and Expenses: Overview of Current Law and Legislation," Congressional Research Service, March 24, 2009.

contributions before the funds expire.[10] It also should be noted that the $1,208 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 Finance Committee 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 $1,208, 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 Finance Committee 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.

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 Finance Committee 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 larger than 7.5 percent of their income through 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-

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[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).

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 Finance Committee 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 Finance Committee 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.

Instituting Efficiencies in Medicare and Medicaid

The Finance Committee 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 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 Finance Committee package 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 Finance Committee bill would reduce Medicare payments to hospitals with high readmission rates to encourage them to do a better job of preventing avoidable readmissions.

The Finance Committee 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 Finance Committee 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.

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[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.

[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.

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 Medicaid is obtaining the best prices for all of the drugs it covers. Finally, the Finance Committee 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

The proposed offsets in the Senate Finance Committee bill are sound policies that would use resources in the health care system more efficiently. They are likely to prove controversial; for example, some people with high-cost employer-sponsored health plans may object to the proposed excise tax on such plans. Yet weakening or eliminating these offsets would not only result in a less efficient health care system but also make it more difficult to provide low- and moderate-income Americans with sufficient subsidies to afford health coverage.

Even at their current levels, the subsidies in the package likely would prove inadequate to make coverage affordable. Weakening the proposed offsets without finding suitable replacements would force policymakers to scale back the subsidies still further.

[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.