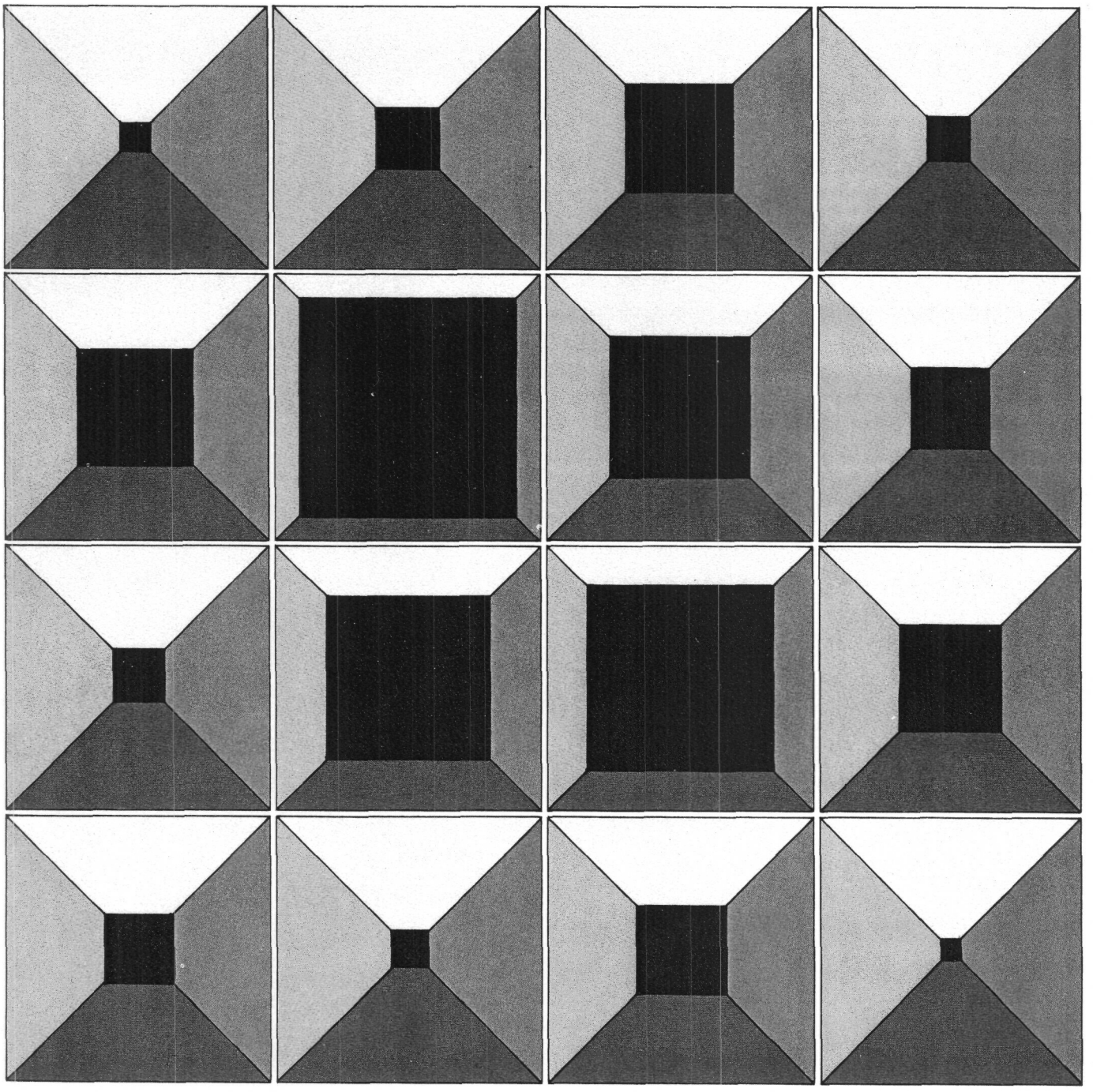
BACKGROUND
PAPER

Tax Subsidies for Medical Care: Current Policies and Possible Alternatives

January 1980
(Reprinted
April 1980)

Congress of the United States
Congressional Budget Office



TAX SUBSIDIES FOR MEDICAL CARE: CURRENT POLICIES AND POSSIBLE ALTERNATIVES

Congressional Budget Office
Congress of the United States

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402

PREFACE

In the current debate over inflation, few issues have aroused more controversy than the rapid increase in health-care costs. This paper, prepared at the request of the Subcommittees on Health and Oversight of the House Ways and Means Committee, examines an important aspect of this issue: tax subsidies for medical care.

Tax Subsidies for Medical Care was prepared by Joshua E. Greene under the direction of James M. Verdier of CBO's Tax Analysis Division and with the assistance of Paul Ginsburg and other members of CBO's Tax Analysis and Human Resources and Community Development divisions. Charles Davenport, Peter Karpoff, and others at CBO provided valuable comments and suggestions on earlier drafts of the paper.

Many people outside CBO gave generously of their time and help during the preparation of this study. Peter Davis and Van-Xe Nguyen of the Joint Committee on Taxation and Roy Wyscarver of the Treasury Department prepared many of the computer runs that provided data for the paper. Numerous people also commented on earlier drafts, including Lawrence Brown, Bruce F. Davie, Deborah Freund, Clark Havinghurst, Joseph Newhouse, Joseph Pechman, Eugene Steuerle, Stanley Surrey, Ronald Vogel, and Ira Tannenbaum. Many other people also provided valuable information, including staff members at the Department of Health, Education, and Welfare and other Executive Branch agencies, several municipal bond firms, state health-care facilities financing authorities, and the American Hospital Association. Linda Brockman and Shirley Hornbuckle prepared the manuscript for publication.

In accordance with CBO's mandate to provide objective and impartial analysis, the paper offers no recommendations of policy options.

Alice M. Rivlin
Director

January 1980

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SUMMARY

Some of the largest federal subsidies for health care result from items that do not appear as direct spending measures: the tax provisions affecting medical care. In fiscal year 1980, the revenue losses resulting from these provisions may exceed $14.5 billion--an amount equal to one-fourth of the federal government's direct expenditures on health care.

Of the possible $14.5 billion in revenue losses, about $9.6 billion results from the exclusion from taxable income of employer contributions to employee health insurance plans--what this paper calls the "employer exclusion." Another $3.1 billion results from the deductibility of health insurance premiums and large out-of-pocket medical expenses. The remaining revenue losses come from the deductibility of charitable contributions to not-for-profit medical facilities and the financing of hospital facilities by tax-exempt bonds. This paper analyzes three of these four tax subsidies: the employer exclusion, the medical expense deduction, and the use of tax- exempt bonds to finance capital projects at private hospitals and medical institutions.

THE EMPLOYER EXCLUSION

The employer exclusion exempts from taxable income all employer contributions to health and accident insurance plans for employees, including plans established by employees themselves. Employees, therefore, receive a discount equal to their marginal tax rate for each dollar of health insurance purchased through employer contributions. This saving provides a powerful incentive for employees to bargain for employer-provided health and accident insurance. It also encourages employers to provide group health coverage, since a dollar of direct cash compensation may be less attractive to employees than a smaller amount of employer-provided health benefits.

While the employer exclusion stimulates health insurance coverage, it has adverse consequences for the level of medical

spending. The exclusion encourages employees to buy more health insurance coverage than they otherwise would, and this in turn encourages more frequent use and more elaborate forms of medical care. As a result, total medical expenditures tend to increase. The incentive to obtain more health insurance is particularly strong because employer contributions are excluded from taxable income without limit. This feature of the exclusion, together with the substantial discounts available to those purchasing group health insurance, eliminates most of the incentive to choose health insurance with cost-containment features. The result is a proliferation of group policies providing full reimbursement for insured medical expenses.

Besides its adverse effect on medical spending, the exclusion has other defects. For example, the tax savings generated by the exclusion are concentrated disproportionately among persons with higher incomes, since the rate of tax subsidy equals the employee's marginal tax rate and tax rates rise with taxable income. The exclusion can also be faulted as a device for securing universal health insurance coverage. Although it gives employers incentives to provide health benefits for their employees, not all do so. Individual health insurance, moreover, is typically much more expensive than group coverage, and the subsidies for individual coverage under the medical expense deduction are generally far less than those provided by the employer exclusion. Thus, it is not surprising that a substantial number of low- and moderate-income households do not have any type of private health insurance. Even after taking into account Medicare, Medicaid, and other government programs, a significant proportion of such households--over 16 percent of those with incomes below $10,000 in 1976--have no form of public or private health-care coverage.

Possible Alternatives

Three alternatives to the employer exclusion are examined in this report. Two of them--limiting the exclusion to a fixed-dollar amount and requiring that tax-subsidized policies have certain features--would serve mainly to reduce the exclusion's inflationary effects. The third--converting the exclusion to a tax credit with a fixed-dollar ceiling--would also bring about a more equal distribution of tax benefits across income groups.

Limiting the Exclusion to a Fixed-Dollar Amount. One of the simplest methods of reducing the inflationary consequences of the exclusion would be to limit it to a fixed-dollar amount, preferably a sum near the cost of a federally qualified Health Maintenance Organization (HMO) or a conventional health insurance policy with significant cost sharing requirements, such as deductibles and coinsurance. A limit of this sort would encourage employees to choose less inflationary health insurance plans, since only plans with incentives to curb spending would most likely be fully subsidized and additional coverage would have to be purchased with taxable dollars. Limiting the exclusion could also benefit individuals who prefer higher cash compensation to more extensive health benefits, if firms responded to the change by substituting cash payments for subsidies to health plans. On the other hand, a fixed-dollar limit would burden firms with the requirement of reporting any excess contributions for health plans to the Internal Revenue Service (IRS), because these sums would become taxable income.

Converting the Exclusion to a Limited Tax Credit. Another option would be to convert the exclusion to a limited tax credit for employer contributions to employee health plans. Under this option, all employer contributions would become taxable income to the employee, but a portion--the first $1,000, for example--would qualify for a tax credit. Converting the exclusion to a tax credit would eliminate the present difference in subsidy rates under the exclusion, since taxpayers at all income levels would receive the same rate of subsidy for each dollar of qualifying employer contributions. The tax credit method would also allow subsidies to be limited to a fixed-dollar expenditure on health insurance, in order to encourage employees to choose less-expensive health plans. Another advantage of the tax credit approach is that it could easily be expanded to provide benefits for taxpayers without employer-provided group insurance who do not itemize their deductions.

One disadvantage of replacing the exclusion with a tax credit is that it could impose a reporting burden on firms with employment-related health plans, since all employer contributions would have to be reported to the IRS as taxable employee income. This burden, however, may not be very great. A tax credit would also leave intact the budgetary defects of the exclusion, such as low visibility and uncontrollability of

expenditures. These problems are characteristic of subsidies that are provided through tax expenditures rather than through direct expenditure programs.

Requiring Specific Features in Health Insurance Plans. A third option, which would also reduce the inflationary consequences of the exclusion, would be to limit the exclusion to employer contributions for health insurance plans with specific features. Two particular limitation proposals have received considerable attention in the last few years as ways of reducing medical costs: limiting the exclusion to health plans with significant cost sharing requirements for all services, and requiring employers to offer a choice of health plans, and to contribute equally to each one. Some proponents of limiting the exclusion have also suggested that qualifying plans contain a minimum set of health benefits. This last suggestion has been made to prevent employees from staying under the ceiling by eliminating coverage for important supplementary services, rather than by accepting coinsurance, deductibles, or membership in an HMO.

The two leading proposals for limiting costs through mandated specific features each have important strengths and weaknesses. The proposal to require cost sharing for all insured services, for example, would increase consumers' sensitivity to medical costs, because consumers would bear some direct expense for all insured services. This change should curb spending and reduce the utilization of medical services. The resulting savings might not, however, be very large. First, many medical services are not that responsive to increases in the out-of-pocket cost of care. For example, the cost sensitivity of spending for hospital care, the component of medical care for which expenditures are growing the most rapidly, is fairly low. Second, even if cost sharing were required for all tax-subsidized health insurance, consumers would still be free to supplement employer-provided coverage out of their after-tax income. If large numbers of consumers purchased extra insurance, despite its probable high cost, much of the decrease in utilization resulting from cost sharing would disappear. Such supplementation would be particularly likely if specific types of cost-sharing provisions such as mandatory coinsurance for hospital services were required.

The proposal to require that employees be offered a choice of health insurance plans and that employers make equal contributions to each one, with a ceiling on all contributions, also stands to reduce medical spending. Under this option, medical outlays could be cut not only through reduced utilization but also through increased competition among providers, since the more expensive health plans would require additional contributions from employees. For significant savings to occur, however, viable prepaid care plans such as HMOs would have to be available. Otherwise, employees might continue to select high-cost insurance offering "first dollar" coverage for all insured services. This has been the experience under the Federal Employees Health Benefits Plan, where the share of membership in alternative practice plans has remained fairly low except in states such as California and Hawaii, which have strong HMOs.

THE MEDICAL EXPENSE DEDUCTION

The medical expense deduction allows taxpayers who itemize their deductions to subtract from taxable income one-half the cost of payments for health insurance, with a maximum deduction of $150, plus the bulk of all remaining out-of-pocket medical expenses that in total exceed 3 percent of adjusted gross income. All payments for medical services, the remaining cost of health insurance, and pharmaceutical purchases above 1 percent of adjusted gross income may be included in this total.

The medical expense deduction has often been described as promoting the taxation of income on the basis of ability to pay. With the rapid growth of health insurance, however, the medical deduction has become for many families a source of tax subsidies for medical costs not covered by their health-insurance policies. For affluent households, who are the prime beneficiaries of the deduction, it can provide generous subsidies for plastic surgery, trips to warm climates, and other types of elective care. Thus, it may be more reasonable to view the deduction as a tax subsidy than as an ability-to-pay provision.

If the medical deduction is viewed as a tax subsidy, it can be faulted in several major respects. First, the pattern of tax savings it provides for different income groups is contrary to most assumptions regarding need. Persons who do not itemize deductions--a group that includes most low- and moderate-income

individuals--cannot benefit from it. At the same time, tax savings per dollar of deductible expenses increase with taxable income, and overall savings among those claiming the deduction go disproportionately to upper-income taxpayers. A second problem is that payments are not available when expenses are incurred; they come only later, when tax returns are filed. Finally, the deduction subsidizes a rather broad spectrum of medical outlays rather than concentrating on very high medical expenses related to catastrophic illness, which can pose the greatest financial hardship to families and individuals.

Possible Alternatives

Several alterations in the medical deduction have been suggested. This report examines three of these proposals: changing the deduction to a tax credit, raising the minimum for subsidized out-of-pocket medical expenses above 3 percent of adjusted gross income, and establishing government-sponsored insurance for "catastrophic" health expenses.

Changing the Deduction to a Tax Credit. Changing the deduction to a tax credit, particularly a refundable credit, would equalize the rate of subsidy for tax-subsidized medical expenses and extend benefits to taxpayers who do not itemize their deductions. Such a change, however, could increase the revenue losses from the provision, unless the rate of credit were set fairly low.

Raising the Minimum for the Deduction. Raising the minimum for the deduction would reduce revenue losses from the provision and concentrate its benefits among taxpayers with particularly heavy medical outlays. Many taxpayers, however, would then face higher tax liabilities, although increases among those with high expenditures could be offset by providing a supplementary tax credit for medical outlays above, say, 10 or 15 percent of adjusted gross income.

Providing Catastrophic Health Insurance. A catastrophic health insurance program would be more effective than the deduction at subsidizing very high medical expenses, particularly for low- and moderate-income persons. Government provision of catastrophic health insurance would be far more costly than the medical expense deduction, however, and would require much greater effort to administer. In addition, providing coverage for all "catastrophic" medical services could increase total

medical spending if doctors and patients felt less constrained in using medical services as a result.

THE USE OF TAX-EXEMPT BONDS TO FINANCE CAPITAL PROJECTS AT PRIVATE HOSPITALS

Current law allows private hospitals, particularly tax-exempt, not-for-profit medical facilities, to obtain low-interest loans for capital projects through tax-exempt bonds. These bonds, which are typically issued by state and local government agencies on behalf of hospitals and other designated public and private institutions, provide significant savings to the organizations for which they are issued. These savings now represent the largest form of federal government support for capital projects at hospitals and other medical institutions. In fiscal year 1980, the revenue loss to the Treasury from tax-exempt hospital bonds is estimated to be about $400 million.

Government subsidies for hospital construction have been justified in the past because many areas of the United States had a shortage of hospital beds. A growing number of researchers, however, have found evidence suggesting this is no longer true. The leading studies on this issue indicate that the nation now has an excess of hospital beds nationwide, although estimates differ on the extent of the excess. Moreover, hospital construction has continued despite the creation of state agencies to monitor the growth of hospital facilities.

If hospitals are to receive federal subsidies, tax-exempt bonds have problems as a vehicle for providing aid. Although the bonds provide savings quickly and with little federal paperwork, they are not now designed to target aid on the most needy projects. As a rule, tax-exempt bonds can be issued to finance any project at a financially-sound hospital for which a certificate-of-need can be obtained from the requisite state health planning agency. In theory, this certification process should limit hospital projects to those for which significant need can be demonstrated. Recent studies, however, question the effectiveness of this process in regulating the growth of hospital facilities. At the same time, the creditworthiness standards imposed by bond markets mean that some needed projects at financially weak hospitals cannot be subsidized by tax-exempt bonds.

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Another problem with the bonds is that a substantial "gap" exists between the savings provided to institutions and the revenues lost to the Treasury. Most studies indicate that only about 70 to 75 percent of the subsidy provided by tax-exempt bonds actually reaches the intended beneficiaries. The rest goes as extra tax savings to bond purchasers in high tax brackets and as fees to the many participants needed to arrange tax-exempt bond financing. The extra tax savings to high-bracket bond purchasers reduce the progressivity of the income tax, while the revenue losses from the bonds have low visibility in the federal budget and are not subject to the regular controls of the budget process.

Maintaining Present Law. The simplest policy option available to the Congress would be to maintain the current law regarding tax-exempt hospital financing. This option would preserve the advantages of using tax-exempt bonds as a subsidy, such as the availability of savings without requiring prior approval from a federal agency. It would also preserve the disadvantages of using tax-exempt bonds. These include uncontrollable expenditures, a regressive effect on the federal tax system, and a relatively high cost of providing funds to the intended beneficiaries. Maintaining present law would also leave untouched the possibility that subsidies will be provided for "unnecessary" projects while deserving projects at financially weak institutions go unsupported. This last problem, however, might also be remedied by improving the current health planning process, rather than changing the availability of tax-exempt bonds.

Eliminating Tax-Exempt Funding for Hospital Projects. Another option would be to prohibit tax-exempt funds for hospital projects. This step would prevent the subsidizing of hospital facilities with questionable need. It would also, however, block access to subsidies for many worthwhile projects, since direct expenditure subsidies for the typical urban or suburban hospital are now limited to mortgage guarantee insurance. If the Congress wished to expand direct expenditure federal subsidies for hospitals in order to compensate for eliminating tax-exempt hospital bonds, the restrictions imposed by current health planning rules would have to be modified. Changing these rules, however, might weaken the incentives for states to limit hospital capacity through regulation. Some health analysts might find such changes more unattractive than the disadvantages

that now arise from subsidizing hospital construction through tax- exempt bonds.

Requiring that Tax-Exempt Hospital Bonds Be General Obligation Issues. A third option would be to require that tax-exempt hospital bonds be "general obligation" bonds backed by the full faith and credit of the issuing government agency. Revenue bonds, backed only by hospital income, would no longer be permitted. These are now the typical form in which tax-exempt hospital bonds are issued.

Limiting tax-exempt hospital bonds to general obligation issues would tend to restrict the number of hospital projects financed by tax-exempt issues, since each governmental unit has a practical ceiling on the volume of general obligation bonds it can issue without being forced to pay high interest rates or jeopardizing its credit rating. If tax-exempt hospital bonds were general obligation issues, the issuing governments might begin to view hospital projects as competing with other projects financed by that government's tax-exempt bonds. State and local governments would then be likely to limit tax-exempt bonds to those hospital projects with the greatest apparent public benefits. In theory, these would be the projects that are most needed, although other factors could also influence the choice of projects to be financed. Financially strong jurisdictions with high bond ratings might also be given an artificial advantage by this option, even though the hospital projects being financed were no more worthy than those from weaker jurisdictions with lower bond ratings.

One difficulty with limiting tax-exempt hospital bonds to general obligation issues is that it could preclude private hospitals in many states from receiving tax-exempt financing. Many states have statutory or constitutional prohibitions against issuing for private projects or institutions tax-exempt bonds backed by the full faith and credit of the issuing government. In other states, hospital bond authorities may issue revenue bonds for private hospitals, but not general obligation bonds. To take into account these legal barriers, the effective date of any provision requiring that hospital bonds be general obligation bonds could be delayed for a few years after enactment. This would allow time for states with legal prohibitions against using general obligation bonds to reconsider these provisions and modify them if they chose.

CHAPTER I. INTRODUCTION

The sharp rise in medical costs during the last several years has generated concern about the effectiveness of current government activities to contain medical spending. To date, the major federal efforts in this area have involved health-planning activities, including state-based controls on the expansion of hospital facilities. Legislation has also been proposed to supplement these controls with a limit on the increase in revenues private hospitals may receive.[1] Despite these efforts, however, medical costs have continued to accelerate.

This paper focuses on a frequently ignored portion of the federal budget that many analysts now consider an important factor in the medical cost spiral: tax expenditures for medical care.[2] These expenditures, which result from tax provisions such as the medical expense deduction, now cost the federal government about $14.5 billion a year in lost tax revenues.[3] This amount is roughly one-fourth the size of the federal government's direct expenditures for programs under the health

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1. For a review of recent cost-containment proposals, see Congressional Budget Office, Controlling Rising Hospital Costs, Budget Issue Paper (September 1979).

2. Tax expenditures are revenue losses that arise from provisions of the tax code that extend special or selective tax relief to certain groups of taxpayers. These revenue losses are called tax "expenditures" because they are payments made through a reduction in taxes rather than a direct grant.

3. See CBO, Five-Year Budget Projections and Alternative Budgetary Strategies for Fiscal Years 1980-1984: Supplemental Report on Tax Expenditures (June 1979), Table 1; and estimates developed in Chapter IV of this paper for the revenue loss from tax-exempt hospital bonds.

budget function, which are expected to exceed $55 billion in fiscal year 1980.[4]

Although tax expenditures for medical care are less visible than direct expenditure programs such as Medicare and Medicaid, they have powerful effects on the price and use of medical services. By subsidizing the cost of health insurance and out-of-pocket medical spending, the tax provisions encourage both the use of health-care resources and the development of more elaborate forms of medical care. Prices and utilization are also affected by tax provisions that lower the cost to hospitals of borrowing for capital improvements. Recognition of these consequences has led the Chairman of the House Ways and Means Committee and other legislators to introduce bills that would impose significant constraints on these tax subsidies.[5]

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4. CBO estimates combined federal outlays and tax expenditures for health care under the health budget function at $69.8 billion for fiscal year 1980. This sum includes approximately $55.6 billion in direct outlays. The remaining $14.1 billion arises from various tax expenditures, including $1.2 billion in foregone revenues attributable to the deductibility of charitable contributions for health-related activities. As much as $400 million more in revenue losses results from tax-exempt hospital bonds for hospital construction now classified under the "General Purpose Fiscal Assistance" budget function. See CBO, Five-Year Budget Projections, Fiscal Years 1980-1984: Tax Expenditures, Tables 1 and 3. If tax expenditures for health care are compared to federal outlays for all health-related programs, including those outside the health budget function, the proportion of direct and indirect expenditures attributable to tax subsidies is approximately 18 percent. See Budget of the United States Government, Fiscal Year 1980, p. 246.

5. See, for example, the "Health Cost Restraint Act of 1979," H.R. 5740, introduced by Chairman Al Ullman of the House Committee on Ways and Means; the "Health Incentives Reform Act of 1979," S. 1968, introduced by Senator David Durenberger of Minnesota; the "Comprehensive Health Care Reform Act," S. 1590, introduced by Senator Richard Schweiker of Pennsylvania; and H.R. 3943, introduced by

Of the four tax provisions generally identified as tax expenditures for health care, three seem most closely linked to the medical sector: the exclusion from taxable income of employers' contributions to employees' health insurance plans, the medical expense deduction, and the ability of hospitals to benefit from tax-exempt bond issues. These three provisions account for roughly $13.1 billion of the revenue losses attributable to tax subsidies for medical care.[6] The fourth tax expenditure--the deductibility of charitable contributions to medical institutions--is not discussed in this paper, because most of the issues it raises involve the deductibility of charitable contributions in general.[7]

ORGANIZATION OF THE PAPER

Chapter II analyzes the exclusion from taxable income of employer contributions to health insurance for employees. This chapter examines the effects of the exclusion on the demand for and extent of health insurance coverage, and it notes the impli-

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Representative James Jones of Oklahoma; all introduced during the 1st session of the 96th Congress (1979).

6. The exclusion from taxable income of employer health contributions is expected to generate about $9.6 billion in revenue losses in fiscal year 1980, while the projected cost for the medical expense deduction is $3.1 billion. The revenue loss from tax-exempt hospital bonds is somewhat harder to project, because not much is known about the assets tax-exempt bonds displace. If these bonds displace mostly taxable issues, the revenue loss could exceed $400 million. For more discussion on this issue, see Chapter IV.

7. For an examination of this subject, see Commission on Private Philanthropy and Public Needs, Giving in America (1975); Martin Feldstein and Amy Taylor, "The Income Tax and Charitable Contributions," Econometrica, vol. 44 (November 1976), pp. 1201-22; and Harold M. Hochman and James D. Rodgers, "The Optimal Tax Treatment of Charitable Contributions," National Tax Journal, vol. 30 (March 1977), pp. 1-18.

cations of the exclusion for the level of medical spending. Three possible changes in the current law are discussed: limiting the exclusion to a fixed-dollar amount of employer contributions, replacing the exclusion with a limited tax credit, and imposing specific restrictions on health plans that qualify for the exclusion.

Chapter III examines the best known of the tax provisions involving health care: the medical expense deduction. In this chapter, the history of the deduction is reviewed and its current role as a tax subsidy is assessed. The chapter also examines several alternatives to the deduction. These include converting the deduction to a tax credit, raising the floor for the deduction, and replacing the deduction with "catastrophic" health insurance provided by the federal government.

Chapter IV examines the use of tax-exempt bonds to finance construction and other capital projects for private hospitals and medical institutions. This chapter reviews the history of federal programs to subsidize hospital construction and analyzes the particular effects of using tax-exempt bonds as a subsidy device. In addition, three policy options are discussed: maintaining current policy, eliminating the use of tax-exempt bonds to finance hospital construction, and limiting tax-exempt hospital bonds to general obligation issues.

CHAPTER II. THE EXCLUSION OF EMPLOYER CONTRIBUTIONS FOR HEALTH INSURANCE FROM EMPLOYEES' TAXABLE INCOME

Section 106 of the Internal Revenue Code excludes from taxable income all contributions made by employers to health and accident insurance plans for employees. In addition, Section 3104 excludes these contributions from the wage base for determining Social Security taxes, although the resulting revenue losses are not considered tax expenditures.[1] For fiscal year 1980, the revenue losses from Section 106 are expected to total almost $9.6 billion, and the losses from Section 3104 are estimated at more than $4 billion.[2] Thus, the exclusion of employer contributions--termed the "employer exclusion" in this paper--is the largest tax expenditure for medical care.[3]

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1. Social Security payments, unlike other federal government outlays, are tied to contributions. Thus, any reduction in contributions is reflected in lower benefits. Tax expenditures, by contrast, are not related to contributions.

2. CBO, Five-Year Budget Projections, Fiscal Years 1980-1984: Tax Expenditures, Table 1; and Eugene Steuerle and Ronald Hoffman, "Tax Expenditures for Health Care," U.S. Treasury Department, Office of Tax Analysis, OTA Paper No. 38 (April 1979), p. 11.

3. The employer exclusion, moreover, is the fifth largest tax expenditure for individuals in the federal income tax. The only larger income tax expenditures for individuals are the deductibility of nonbusiness state and local taxes ($19.1 billion in fiscal year 1980), the exclusion of pension contributions and earnings ($12.9 billion), the special tax treatment of capital gains income ($10.1 billion), and the tax treatment of capital gains realized at death ($10.0 billion). See CBO, Five-Year Budget Projections, Fiscal Years 1980-1984: Tax Expenditures, Table 1.

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LEGISLATIVE HISTORY AND RATIONALE

The legislative history of the employer exclusion parallels that for many fringe benefits whose tax-exempt status is not codified.[4] Originally, employer contributions to employee pension plans were not subject to tax, because noncash fringe benefits were generally considered not to be taxable income. In 1943, an Internal Revenue Service (IRS) ruling made this exemption explicit for employer contributions to group health insurance policies.[5] Employer contributions to individual health insurance policies, however, were declared to be taxable income in an IRS Revenue Ruling in 1953.[6] Section 106, which was introduced in 1954, was enacted to reverse the 1953 ruling. As a result, all employer contributions to employee health and accident plans are now excluded from taxable income.

Although the legislative history of Section 106 indicates only a desire to make uniform the tax treatment of employer contributions to group and individual health insurance plans, several other purposes for the exclusion can be suggested. For example, the exclusion may be considered a device to make uniform the tax treatment of employer health contributions and other noncash fringe benefits, most of which are not included in taxable income.

The exclusion can also be viewed as a special subsidy to taxpayers with employer-subsidized health insurance. From this perspective, it can be compared with other measures to promote health

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4. For a further description of the tax treatment of fringe benefits, see "Taxation of Fringe Benefits," prepared for the Task Force on Employee Fringe Benefits, House Committee on Ways and Means, by the staff of the Joint Committee on Taxation, August 11, 1978; and "Tax Treatment of Fringe Benefits," prepared statements before the House Committee on Ways and Means, 95th Congress, 2nd sess., August 15, 1978.

5. See Special Ruling, October 26, 1943, CCH Federal Tax Service, vol. 443, paragraph 6587.

6. See Revenue Ruling 210, IRS Cumulative Bulletin, 1953, vol. 2, p. 114.

insurance coverage, such as direct government provision of comprehensive health coverage--what is often called "national health insurance." This view of the exclusion has been adopted by the three federal agencies that record tax expenditures--the Office of Management and Budget, the Congressional Budget Office, and the Joint Committee on Taxation of the U.S. Congress. It is also accepted by leading tax analysts.[7]

DISTRIBUTION OF TAX SAVINGS

The distribution of savings to taxpayers from the exclusion cannot be calculated directly, since employees do not report the value of employer-provided health insurance premiums on their tax returns. By making certain assumptions about the cost of health insurance and the pattern of coverage among employees at different income levels, however, a rough estimate of the distribution of tax savings can be made. The U.S. Department of the Treasury, in a recent study of tax expenditures for health care, has provided such an estimate for 1977 (see Table 1). According to the Treasury study, average tax savings rise sharply with taxpayer income. Taxpayers with expanded incomes below $20,000 averaged less than $10 a year in tax savings from the provision, while those with expanded incomes of $30,000 or more averaged savings of more than $190.[8] According to the Treasury estimate, more than half of the total savings went to the 20 percent of all taxpayers with expanded incomes of $20,000 or more. This pattern of benefits is the opposite of what would normally be expected from a subsidy based on need.

Although tax savings from the exclusion are concentrated among upper-income taxpayers, taxpayers at all income levels do benefit. Of the roughly 163 million persons in the United States with private health insurance coverage in 1976, more than 122 million--

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7. See, for example, Stanley S. Surrey, Pathways to General Tax Reform (Harvard University Press, 1973), pp. 192-193.

8. "Expanded income" is a broader definition of taxpayer income than adjusted gross income. In addition to adjusted gross income, it includes the untaxed part of capital gains, percentage cost depletion, and other tax preferences subject to

TABLE 1. DISTRIBUTION OF TAX SAVINGS FROM THE EXCLUSION OF EMPLOYER CONTRIBUTIONS TO EMPLOYEE HEALTH INSURANCE PLANS, 1977

Expanded Income Class (in Dollars)	Number of Taxpayers in Income Class (in Thousands)	Total Tax Savings for All Taxpayers in Income Class (in Millions of Dollars)	Average Tax Savings per Taxpayer in Income Class (in Dollars)	Percent of Total Tax Savings to Taxpayers in Income Class	Percent of All Taxpayers in Income Class
Less than 5,000	24,727	91	4	1.6	27.8
5,000- 10,000	19,300	494	26	8.9	21.7
10,000- 15,000	15,145	814	54	14.6	17.0
15,000- 20,000	12,022	1,028	86	18.5	13.5
20,000- 30,000	11,891	1,547	130	27.8	13.4
30,000- 50,000	4,433	882	199	15.9	5.0
50,000-100,000	1,182	456	386	8.2	1.3
100,000 and over	297	248	835	4.5	0.3
All Returns	88,997	5,560	62	100.0	100.0

SOURCES: Treasury Department tax model, 1977 tax law at 1977 income levels; and Steuerle and Hoffman, "Tax Expenditures for Health Care," Table 3.

about three-fourths--had employer-subsidized health insurance.[9] Thus, the exclusion provides tax savings to a large group of taxpayers--much larger, for example, than the number of taxpayers now itemizing deductions (about 25 million).

ANALYSIS

Effects on Relative Tax Liabilities

The employer exclusion has two effects on tax liabilities that could be said to create inequities in the tax system. First, the exclusion favors persons who receive part of their incomes in the form of health benefits over those whose earnings come entirely in taxable forms (wages and salaries, for example). Although the differences in tax liabilities are not great for low- and moderate-income families, they can be significant for workers in relatively high marginal tax brackets. A worker in the 40 percent tax bracket, for example, whose employer offers a health insurance plan worth $500, saves $200 in income taxes as a result of the exclusion. By comparison, self-employed persons or workers who receive higher wages rather than employer-subsidized health insurance would pay $200 more in taxes and could not buy as much insurance with their after-tax wages.

Second, the exclusion also tends to reduce the progressivity of the income tax. Because tax benefits from the exclusion of income depend on a taxpayer's marginal tax rate, upper-income taxpayers with employer-provided health plans benefit more from the exclusion than do other workers. For example, the hypothetical employee in the 40 percent marginal tax bracket, whose employer contributes $500 a year to a health plan, receives $200 in tax savings from the exclusion. Another worker with the same health benefits but with a marginal tax rate of only 20 percent saves only $100. The exclusion also benefits upper-income taxpayers more than others to the extent that upper-income employees

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the minimum tax. It also limits the deduction of investment interest to the amount of investment income.

9. U.S. Bureau of the Census, Survey of Income and Expenditures, 1977 (Census, SIE, 1977).

work for organizations that provide more generous health insurance packages.

Effect on Health Insurance Coverage

Although estimating the effect of the exclusion on health insurance coverage is difficult, the available evidence suggests it has been substantial. Many studies indicate that the demand for health insurance appears to be sensitive to the cost of coverage even after taking other factors such as the cost of care into account.[10] The exclusion is a prime factor in lowering the cost of coverage, although other elements such as the development of employer-provided group coverage have also played a role.[11] With the exclusion, employees receiving employer-paid health benefits can obtain these benefits for significantly less money than they would if the benefits were taxable income. An employee in the 25 percent marginal tax bracket, for example, receives $1 in after-tax benefits from each dollar in employer-paid group health benefits, as opposed to 75¢ of income if the contributions were taxable. Because of the savings from the exclusion, employers can lower their compensation costs and increase the after-tax income

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10. See, for example, Charles E. Phelps, Demand for Health Insurance: A Theoretical and Empirical Investigation, Report No. R-1054-OEO (Rand Corporation, July 1973). According to Phelps, a 1 percent decrease in the cost of health insurance coverage (holding constant a number of other variables, including the cost of medical care) will result on average in a 0.6 to 0.7 percent rise in the extent of coverage.

11. Employer-provided group health insurance has significantly lowered the cost of insurance by allowing major savings in administrative costs. Several studies have found that administrative costs for private group health insurance plans are generally less than 15 percent of total plan outlays, as compared with 45 percent or more for individual health insurance policies. See, for example, Bridger M. Mitchell and Ronald J. Vogel, "Health and Taxes: An Assessment of the Medical Deduction," Southern Economic Journal, vol. 41 (April 1975), pp. 660-72 at p. 664; and Marjorie S. Mueller, "Private Health Insurance Plans in 1976: An Evaluation," Social Security Bulletin, vol. 41 (September 1978), p. 10.

of their employees at the same time by replacing direct wage and salary payments with a smaller amount of employer-paid health benefits. Thus, the exclusion gives employers, as well as employees, a strong incentive to provide employer-paid health insurance benefits.[12]

Although the exclusion appears to have encouraged the spread of health insurance, it has not resulted in universal coverage. Many employers still have no health plans for their employees, and the high cost of individual coverage has kept many low- and moderate-income individuals from buying health insurance on their own.[13] Although some of these individuals qualify for coverage under government programs, such as Medicaid and Medicare, many do not. As of 1976, more than 16 percent of all persons with annual incomes under $10,000 had neither private health insurance nor access to government-provided coverage or care (see Table 2).[14]

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12. Between 1950 and 1974, the share of workers with hospitalization insurance rose from 48.6 percent to 69.6 percent, while the share of workers with coverage for regular medical expenses increased from 16.4 percent to 66.5 percent. Similar increases were also reported for other tax-subsidized, employer-provided fringe benefits. See Alfred M. Skolnik, "Twenty-Five Years of Employee Benefit Plans," Social Security Bulletin, vol. 39 (September 1976), p. 6.

13. The tax code does provide some limited assistance to persons with individual-paid health insurance through the medical expense deduction, which is discussed in the next chapter. However, the extent of support is quite limited: only half of the first $300 of premiums, plus the remaining premiums to the extent that allowable out-of-pocket medical costs exceed 3 percent of adjusted gross income, can be deducted. Furthermore, the subsidy is available only to taxpayers who itemize their deductions. Thus, the large majority of low- and moderate-income taxpayers for whom the standard deduction (now called the "zero bracket amount") exceeds all itemized deductible expenses receive no specific tax reduction when they purchase health insurance themselves.

14. For a further analysis of current gaps in health insurance coverage in the United States, see CBO, Profile of Health Care Coverage: The Haves and Have-Nots, Background Paper (March 1979).

TABLE 2. HEALTH INSURANCE COVERAGE IN THE UNITED STATES BY INCOME LEVEL: 1976

Income Level (in Dollars)	Total Population with Coverage	Population without Coverage	Percent Total of Population without Coverage
Less than 5,000	23,111,792	4,873,123	17.4
5,000- 9,999	35,392,435	7,021,263	16.6
10,000-14,999	40,581,681	4,106,319	9.2
15,000-19,999	34,953,210	2,507,093	6.7
20,000-29,999	37,441,287	2,068,800	5.2
30,000 and Over	18,510,910	949,477	4.9
All Incomes	189,991,307	21,526,075	10.0

SOURCE: Census, SIE, 1977, as adjusted by CBO for under-reporting of public health insurance.

Another important feature of the exclusion as a means of promoting coverage is that it imposes no requirements as to the type of health insurance coverage required for tax savings. All employer contributions to an employee's health or accident plan qualify for the exclusion, although health plans administered by a firm for its own employees must satisfy certain nondiscrimination standards for the benefits provided to be tax-exempt.[15] Thus,

15. Under current tax regulations, payments from a fully self-administered plan can be excluded from taxable income only if the following standards are met: the plan must not discriminate in favor of "highly compensated individuals," defined as the top five company officers, stockholders with 10 percent or more of company shares, and the top 25 percent of all employees besides officers and stockholders; and the plan must benefit 70 percent or more of all employees (80 percent or more if 70 percent or more employees are eligible to participate). The law allows firms to exclude employees under

employees with very different types of coverage will all receive tax savings to the extent their premiums are paid by their employers.[16]

Effect on Medical Spending

The exclusion of employers' health contributions from taxable income generates higher medical spending, to the extent it brings about greater health insurance coverage. Coverage, in turn, tends to stimulate medical spending in at least three ways. First, because it lowers the out-of-pocket cost of health care, it encourages consumers to seek care. Second, it reduces patients' awareness of and sensitivity to the difference in price among providers. Third, by lowering the risk of nonpayment, insurance promotes unconstrained use of costly forms of care. When insurance covers the full cost of care, as is true for inpatient hospital care under many current plans, doctors in particular have little incentive to restrain costs. On the contrary, they are encouraged to order more tests and use more services, because the gains from saving money are small while the risks in potential malpractice liability for deferring services are great. The cumulative effect of these patterns, many analysts believe, contributes significantly to inflation in the medical sector.[17]

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25 years of age, part-time and seasonal workers, workers with less than three years of service, nonresident alien employees, and employees covered by an agreement between employee representatives and the employer (for example, workers covered by a labor union plan). See Internal Revenue Code, Section 105(h), 1979. In 1978, the Carter Administration proposed that these same requirements be applied to all employer-group health insurance plans. However, the Congress did not follow this recommendation.

16. For further discussion of the problems in coverage resulting from the current exclusion, see Alain C. Enthoven, "Consumer-Centered vs. Job-Centered Health Insurance," Harvard Business Review, vol. 57 (January-February 1979), pp. 141-52.

17. See Joseph P. Newhouse, "The Structure of Health Insurance and the Erosion of Competition in the Medical Marketplace," in Federal Trade Commission, Competition in the Health Care

The employer exclusion is especially likely to raise medical spending, because it encourages employees to choose the most expensive type of coverage offered. This is particularly true for employees in firms that pay the entire premium cost.[18] The tax law gives employers some incentive to choose cost-minimizing plans, since the employer's deduction for business expenses eliminates only part of the difference in cost between more and less expensive health policies. For employees, however, the exclusion does not have this effect, because all employer contributions, no matter how large, are excluded from taxable income.

Because the most expensive coverage generally eliminates all or most out-of-pocket medical payments, the effect of the exclusion on medical expenditures is invisible to many workers. Costs do emerge, however--often as higher prices or larger premiums. The resulting costs for medical care fall particularly hard on those least able to afford them, since persons with low to moderate incomes are the ones most likely to be uninsured. All persons, however, end up paying more by devoting larger shares of their incomes to medical care.

Low Visibility and Controllability of Expenditures

Most direct federal expenditure programs require annual appropriations that are subject to normal Congressional review. Because the employer exclusion is a permanent provision of the tax code, however, it is not subject to regular review and the revenue

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Sector: Past, Present, and Future (March 1978), pp. 270-87; and Martin Feldstein and Amy Taylor, The Rapid Rise in Hospital Costs, Report to the Council on Wage and Price Stability (January 1977). In many instances, the increase in services represents a real rise in quality. In some cases, however, it may not, and it is often hard to determine when additional services represent better care as well as higher costs.

18. During 1978, more than 61 percent of the employees with new group health coverage were enrolled in plans for which employers paid the entire cost. See Health Insurance Institute, New Group Health Insurance Policies Issued in 1978 (Washington, 1979).

losses it generates go largely unobserved. In addition, revenue losses from the exclusion cannot be controlled, because they result from automatic entitlements for individual taxpayers. This feature is shared by the two major federal expenditure programs for health care, Medicare and Medicaid. Most direct spending programs, however, are subject to greater control.

ALTERNATIVES TO THE CURRENT EXCLUSION

By changing the exclusion or replacing it with another means for subsidizing health insurance, some of its disadvantages could be alleviated. In this section, three alternatives to the current provision are analyzed: limiting the amount of employer contributions that qualify for the exclusion; converting the exclusion to a limited tax credit for employer contributions to employee health plans; and restricting the exclusion to contributions for plans with specific features designed to contain medical costs.

Limiting the Exclusion to a Fixed-Dollar Amount

If curbing the inflationary effects of the exclusion is of primary concern to the Congress, one way to achieve this goal would be to limit the amount of tax-free employer contributions to employees' health insurance plans. A restriction of this sort would induce employees to request plans with premiums that did not go above the ceiling, since employer contributions above the limit would represent taxable income to employees. If the ceiling were sufficiently low, workers would be encouraged to seek plans with built-in features that keep premiums low and discourage excessive medical spending. These plans generally involve either the use of copayments and deductibles or membership in prepaid health plans such as health maintenance organizations (HMOs). Copayments and deductibles both require patients to pay part of the cost for all insured services, whereas HMOs have internal incentives to conserve on medical services.

Limiting the amount of tax-free employer health contributions could have a number of benefits. First, revenue losses from the exclusion would grow less rapidly, although actual tax revenues would increase only if employer health contributions were converted into taxable wages rather than other tax-free benefits. Second, the difference in subsidies received by taxpayers at dif-

ferent income levels would diminish, since the exclusion would shield less income from tax. Third, limiting the exclusion would make tax policy more consistent with current federal initiatives to contain medical spending. This would be especially true if the ceiling were set at or below the level of a health plan with cost-containing features, such as deductibles and coinsurance, or the cost of membership in a prepaid health plan. Fourth, the restriction might heighten the visibility of the exclusion, since employees and legislators would know how much income the exclusion could shield from tax.

Limiting the exclusion would have certain disadvantages, however. It could, for example, be complicated to administer. Firms making health insurance contributions over the ceiling would have to report the amounts they paid for health insurance for their employees. Doing so could create some difficulties, because the insurance is normally purchased as a package item and its cost depends not only on the number of employees and their family status, but also on the age mix of workers and possibly other factors as well.[19] In addition, the IRS would have to add health insurance contributions to the list of business expenses for which firms are audited. Another problem with imposing a limit is that it might not always have the desired incentive effects on health insurance coverage. If a single ceiling were established, employees in states where health insurance costs were relatively low might be able to obtain extensive coverage tax-free. This problem could be overcome by establishing different ceilings in different states or metropolitan areas. Setting multiple ceilings, however, would further complicate the administration of the exclusion unless a readily available price, such as the average cost of a federally qualified HMO in an area, were used to set the ceiling.

A further problem with limiting the exclusion is that it could add to financial burdens on low- and moderate-income families. With a less generous exclusion, employer contributions for

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19. In practice, employers would probably solve this problem by imputing the average cost of insurance to each covered worker, perhaps with different contributions for those with and without dependents. The Federal Employees Health Benefits Plan, for example, follows this approach.

health insurance might decrease. This decrease in contributionscould, in turn, bring about gaps in coverage for some employees unless a viable prepaid health plan existed in the area and employer contributions covered the cost of membership. If gaps in coverage did arise, low-income workers would be most adversely affected, since they would find it most difficult to purchase supplementary coverage or to pay directly for services themselves.

Finally, placing a fixed-dollar limit on the exclusion would not eliminate the exclusion's other weaknesses, such as the uncontrollability of expenditures and the concentration of tax benefits among the affluent. To correct these problems, the exclusion would have to be changed still further.

Replacing the Exclusion with a Limited Tax Credit

Another option would be to replace the current exclusion with a limited tax credit. Under this option, all employer contributions for employees' health plans would be taxable income to the employees. At the same time, employees would be allowed a limited tax credit for these benefits, such as 20 percent of the first $600 in employer contributions.

Replacing the exclusion with a limited tax credit would have important advantages. Like the ceiling described earlier, the tax credit would limit tax subsidies for employer contributions to a maximum dollar amount. Thus, the credit would weaken the incentives to acquire extensive health insurance coverage now created by the exclusion, thereby encouraging employees to choose less comprehensive--and presumably, more cost-containing--health insurance. The tax credit approach, however, might also make employees more aware of the cost of their health insurance than would a fixed-dollar ceiling on the exclusion, because they would have to report as taxable income the full amount of the employers' contributions. This increased awareness could, in turn, result in greater pressure on health-care providers to hold down medical costs. In addition, the tax-credit approach would eliminate the regressivity of tax savings from the exclusion, because employees at all income levels would receive the same rate of subsidy for each dollar of employer-provided health insurance contributions below the maximum qualifying amount for the credit. With the existing exclusion, by contrast, tax subsidies per dollar of

employer contribution rise with taxable income, because the rate of subsidy equals the taxpayer's marginal tax rate.

The tax-credit approach would also have disadvantages, however. First, each firm offering employer-subsidized health benefits would have to calculate and report the amount of contributions it provides for each employee. As mentioned before, this would create a problem for firms, since employers would have to decide whether to report equal contributions for all employees or to differentiate contributions based on an employee's age, family size, or other characteristics. In addition, the duty to report employer contributions would require the IRS to monitor this activity. Second, and perhaps more important, converting the exclusion to a tax credit would not eliminate the basic problems caused by using a tax provision, rather than a direct expenditure program, to subsidize health insurance. Thus, federal subsidies for employer health contributions would remain largely invisible, although a fixed-dollar ceiling on the amount subject to the credit would tend to limit the size of revenue losses. Replacing the exclusion with a tax credit would also do nothing to provide benefits to persons without employer-subsidized group health plans who do not itemize their deductions. To assist these persons, the credit would have to be applicable to individual payments for health insurance.[20] This could be done very simply, although it would allow some taxpayers to claim both a tax credit and a deduction for part of their health insurance payments unless the current rules for deducting health insurance premiums through the medical expense deduction were also changed.

Limiting the Exclusion to Plans with Certain Features

A third option for changing the exclusion would be to limit tax-free employer contributions to those for plans with particular features designed to make patients and health-care providers more sensitive to costs. Some analysts, for example, have urged that employer contributions be channeled into policies with substantial

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20. A bill embodying this principle has been introduced in the present Congress by Representative Paul S. Trible. See "Congressman Paul Trible Introduces Health Insurance Tax Credit Bill," Congressional Record, June 18, 1979, pp. H-4688-4690.

requirements for coinsurance and deductibles, on the assumption that the absence of these provisions has generated inflation in the medical sector.[21] Other analysts have recommended requiring employers to offer employees a choice of health-care plans and to provide the same contribution to each one, in order to increase the attractiveness of prepaid medical plans and to encourage price competition among insurers and health-care providers.[22] This last option has sometimes been paired with the idea of requiring all plans to contain a minimum set of benefits as a way of assuring that all employees have an adequate level of coverage.[23] By itself, such a requirement would tend to increase spending, although it would improve coverage for many employees. If coupled with a ceiling on tax-free employer health contributions, however, it could prevent employees from escaping cost-containment measures by eliminating coverage for such items as catastrophic medical expenses.

Mandating Cost Sharing in Tax-Subsidized Policies. Requiring subsidized health plans to contain cost-sharing provisions such as deductibles and coinsurance could help to restrain medical costs

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21. See, for example, Feldstein and Taylor, The Rapid Rise of Hospital Costs. Representative James R. Jones of Oklahoma has introduced a bill to this effect that would limit the exclusion to employers' payments for HMOs and to plans with a coinsurance rate of 25 percent for all hospital expenses up to a maximum out-of-pocket expense of $2,000 or 15 percent of adjusted gross income. See "A Bill to Limit the Business Deduction Available for Health Insurance Premiums," H.R. 3943.

22. See, for example, Enthoven, "Consumer-Centered vs. Job-Centered Health Insurance." Several bills incorporating this approach have been introduced during the 96th Congress. These include the "Health Cost Restraint Act of 1979," H.R. 5740, introduced by Chairman Al Ullman of the House Committee on Ways and Means; and the "Health Incentives Reform Act of 1979," S. 1968, introduced by Senator David Durenberger of Minnesota.

23. See S. 1590, "Comprehensive Health Care Reform Act," introduced by Senator Richard Schweiker of Pennsylvania.

by reducing the use of medical services. In particular, advocates of this option believe that cost sharing for hospital services would generate large savings in medical expenditures, since hospital care represents the largest source of spending increases in the medical sector. Numerous studies have shown that the demand for medical care is sensitive to the price of care as perceived by the patient. Thus, cost-sharing provisions should lead to lower utilization by increasing the out-of-pocket costs consumers pay for insured services.

Although mandatory cost sharing has strong theoretical appeal as a cost-saving measure, the overall savings from this approach could be fairly small. First, cost sharing is not likely to have much impact on the prices of individual services. When care is needed, patients are not very sensitive to cost differentials among health-care providers. Even with cost sharing, health insurance is likely to dilute sharply the price differentials among health-care providers. Second, although the demand for some services is fairly sensitive to price, the responsiveness of demand specifically for hospital care--the largest and most rapidly growing component of medical outlays--is rather low.[24] Thus, cost sharing may not have much impact on the utilization for a large segment of medical services. It could, however, expose many patients--particularly those with low and moderate incomes--to a great deal of financial risk. Third, because of the risks created by cost sharing, some workers might choose to supplement their health coverage with policies that filled the gaps in their employer-provided plans, even if they had to pay the premiums with after-tax dollars. If these plans provide first-dollar coverage, they would eliminate whatever deterrents to utilization were created by cost sharing in the employer's policy, since these supplementary plans would eliminate the need for patients to bear any cost at the time care is received. If a sizable number of workers chose to supplement their basic employer policies in this way, the net effects of cost sharing on employer-provided insurance could ultimately be negligible. A recent study by several

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24. CBO's review of recent studies of the demand for medical care indicates that decreasing the extent of coverage for hospital care from 100 percent to 75 percent would reduce the volume of hospital admissions by 7 percent at most and would reduce total hospital bills by about 17 percent.

Rand Corporation economists suggests that the chance of such massive supplementation would be small.[25] The experience with Medicare, however, suggests otherwise, and the steady rise in medical costs makes it more rather than less likely for widespread supplementation to occur.[26]

Mandatory Choice of Plans with Equal Contributions up to a Ceiling. Requiring employers to offer a choice of health-care plans, including at least one option for comprehensive, prepaid care such as HMOs provide, and giving equal employer contributions for each, is another proposal that could help contain medical spending. This proposal would encourage insurers and health-care providers to compete, because employees would have to pay higher premiums for more expensive health plans. In addition, the requirement that employees be given the option of joining an HMO or similar organization, when one exists in the vicinity, could encourage the growth of HMOs, particularly if the definition of

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25. See Emmet B. Keeler and others, "The Demand for Supplementary Health Insurance, or Do Deductibles Matter?" Journal of Political Economy, vol. 85 (August 1977), pp. 789-801.

26. The likelihood of massive supplementation would be reduced if cost-sharing requirements were made flexible, so that persons with different preferences about copayments and deductibles could have some choice about the services to which the payments should apply. This kind of flexibility could be achieved if, instead of limiting the exclusion to contributions for plans with particular cost-sharing features, the restriction involved an overall premium limit but stipulated that certain kinds of coverage, such as coverage against catastrophic expenses, must be provided. In this case, employees would have some choice of how the premium limits were to be reached--through deductibles, copayments, or the elimination of coverage for less commonly insured services such as dental care. At the same time, employees would not be able to avoid making some change in coverage that would provide incentives to reduce utilization.

HMO were made somewhat flexible.[27] Several studies have shown that HMOs can generate significant cost savings and help lower prices where they exist.[28] Mandating that employees be given the option of joining an HMO could thus increase the possibility for cost savings.

One problem with requiring that employees be given a choice of health plans is that the current "overinsurance" might not be eliminated unless firms set their contributions at the level of one of the less extensive plans. This approach, however, could bring about significant gaps in coverage for low- and moderate-income employees, unless the premiums equalled the cost of a comprehensive prepaid health care plan. For that reason, most proposals of this type would set the ceiling for employer contributions at or about this level.[29]

The success of this option also depends heavily on the availability of alternative health-care plans. Although these

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27. Current law already requires that employers with more than 25 employees make available membership in a federally qualified HMO if one exists nearby. This provision has not been veryeffective at encouraging HMO membership, however, because few HMOs have been willing to go through all the steps required to become federally qualified.

28. See, for example, Clifton R. Gaus and others, "Contrast in HMO and Fee-for-Service Performance," Social Security Bulletin, vol. 39 (May 1976), pp. 3-14; Harold Luft, "How Do Health Maintenance Organizations Achieve Their Savings?", New England Journal of Medicine, June 15, 1978; and John K. Iglehart, "HMOs are Alive and Well in the Twin Cities Region," National Journal, July 22, 1978, pp. 1160-65.

29. See, for example, "Health Cost Restraint Act of 1979," H.R. 5740, introduced by Representative Ullman; "Health Incentives Reform Act of 1979," S. 1485, introduced by Senator Durenberger; and "Comprehensive Health Care Reform Act," S. 1590, introduced by Senator Schweiker.

have developed in some areas, their growth has been slow in others.[30] Thus, without more rapid growth of prepaid health plans, savings from this option could be very small.

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30. See Enthoven, "Consumer-Centered vs. Job-Centered Health Insurance," and "Health Care Costs," National Journal, May 26, 1979, pp. 885-89.

CHAPTER III. THE MEDICAL EXPENSE DEDUCTION

The second largest of the tax expenditures for medical care is the itemized deduction for out-of-pocket medical expenses. This provision is expected to reduce federal revenues by about $3.1 billion in fiscal year 1980.[1]

The medical expense deduction actually consists of two separate deductions: one for health insurance premiums, and one for so-called "extraordinary" medical expenses--that is, out-of-pocket expenditures that exceed what is thought to be a "normal" percentage of household income. Under the health insurance portion, taxpayers may deduct one-half of all health insurance premiums, with a maximum deduction of $150. The deduction for extraordinary medical outlays allows taxpayers to deduct most types of medical expenditures, the combined value of which exceeds 3 percent of adjusted gross income. All payments for medical services, including any remaining health insurance premiums and all expenditures for drugs and medicines that exceed 1 percent of adjusted gross income, may be counted toward this total.

LEGISLATIVE HISTORY

The medical expense deduction was introduced into the tax code in 1942, when taxpayers were allowed to deduct from taxable income all medical expenses over 5 percent of net income, with a maximum deduction of $1,250 for single taxpayers and $2,500 for couples filing joint returns. Since that time, the threshold, or minimum level, of deductible expenses has been lowered, while the ceiling on deductible expenses has been raised. In 1948, the minimum was changed to 5 percent of adjusted gross income and the ceiling on the deduction was raised to $1,250 per exemption, with a maximum deduction of $2,500 for single taxpayers and $5,000 for those filing joint returns. In 1951, the 5 percent floor was eliminated for taxpayers 65 and older.

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1. See CBO, Five-Year Budget Projections, Fiscal Years 1980-1984: Tax Expenditures, Table 1.

In 1954, ceilings on the deduction for taxpayers were doubled and the minimum level of deductible expenses was lowered to the present level of 3 percent, on grounds that the previous 5 percent threshold "does not allow the deduction of all extraordinary medical expenses."[2] In addition, a 1 percent minimum for out-of-pocket expenses for drugs and medicines was introduced for all taxpayers, and taxpayers 65 and older were allowed to deduct all health insurance premiums without limit. In 1961, the ceilings on the deduction were raised again, while in 1964 the limitation on deductible drug expenses was eliminated for taxpayers 65 and older. In 1967, the 3 percent floor for deductible pharmaceuticals was restored for taxpayers 65 and older, but the other ceilings on the deduction were removed. In addition, the deduction for health insurance was changed so that all taxpayers could deduct half of the first $300 of health insurance premiums without regard to any limitation. This was done in part because the basic deduction was said to discourage individuals from purchasing health insurance.[3]

In 1978, an attempt was made to simplify the deduction and eliminate the separate subsidy for health insurance premiums now provided by Section 213(b). A proposal included in the House version of the Revenue Act of 1978 would have eliminated both the separate deductibility of health insurance premiums and the 1 percent floor on deductions for drug and medicine purchases. Deductible drug expenses would have been limited, however, to prescription drugs and insulin.[4] The net effect of this change would have been to make health insurance premiums deductible only to the extent that out-of-pocket medical expenses exceeded 3 percent of adjusted gross income. The Senate version of the bill, however, did not include these changes, and they were deleted

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2. See Internal Revenue Code of 1954, House Committee Report, U.S. Congressional and Administrative News, pp. 4054-55, and Senate Committee Report, same volume, p. 4666.

3. See Social Security Amendments of 1965, Report of the House Ways and Means Committee on H.R. 6675, 89th Cong., 1st sess. (1965), p. 137.

4. See H.R. 13511, Sec. 112, as passed by the U.S. House of Representatives on August 10, 1978.

from the final version of the act.[5] Thus, the medical deduction remains basically as it was following passage of the Social Security Act Amendments of 1965.

DISTRIBUTION OF TAX SAVINGS

The distribution of tax savings from the deduction as a whole is displayed in Table 3. Table 4 shows savings from the deduction for extraordinary medical expenses in particular. As the tables indicate, the average tax saving from both portions of the deduction increases with taxpayers' income. At 1978 income levels, taxpayers with expanded incomes between $5,000 to $10,000 who claimed the deduction saved about $98 on average from the two parts. For taxpayers with expanded incomes between $50,000 and $100,000, the average saving was more than $300. Taxpayers at the upper end of the income scale also received a disproportionate share of the total savings from the part of the deduction for extraordinary medical expenses. For example, at 1978 income levels, the Treasury Department's tax model estimates that taxpayers with expanded incomes over $50,000 accounted for 4.9 percent of all itemized medical expenses and 6.4 percent of the deductible amounts. These taxpayers, however, received 14.5 percent of the savings from this part of the deduction.

The concentration of tax savings among upper-income taxpayers comes about for two reasons. First, the proportion of taxpayers itemizing their deductions rises sharply as income increases. Second, tax savings depend on taxpayers' marginal tax rates, which, in turn, depend on their incomes. Taxpayers with higher taxable incomes face higher marginal tax rates. Thus, they receive proportionately higher subsidies for each dollar of deductible expenses. Taxpayers in the 50 percent bracket, for example, receive a tax saving of 50¢ for each dollar of deductible expenses, while taxpayers in the 20 percent marginal rate bracket save only 20¢ for each dollar of deductible outlays.

The increase in benefits produced by the rising rate of subsidy is offset, to some extent, because the floor for the

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5. See Conference Report on H.R. 13511, 95th Cong., 1st sess., October 15, 1978, p. 201.

TABLE 3. DISTRIBUTION BY INCOME LEVEL OF TAX SAVINGS FROM THE MEDICAL EXPENSE DEDUCTION

Expanded Income Class (in Dollars)	Number of Returns with: Either Medical Expense Deduction[a] (in Thousands)	Separate Deduction for Health Insurance Premiums (in Thousands)	Separate Deduction for Extraordinary Medical Expenses[b] (in Thousands)	Percent of All Returns in Income Class with Medical Deduction
Less than 5,000	309	238	282	1.4
5,000- 10,000	1,650	1,382	1,472	8.8
10,000- 15,000	2,978	2,529	2,261	21.5
15,000- 20,000	3,425	2,975	2,291	29.5
20,000- 30,000	5,424	4,900	2,918	41.9
30,000- 50,000	3,408	3,215	1,299	58.8
50,000-100,000	856	819	205	60.5
100,000-200,000	162	156	22	61.2
200,000 and over	42	40	3	65.1
All Returns	18,253	16,255	10,754	20.4

(continued)

SOURCE: Treasury Department tax model, 1979 tax law at 1978 income levels.

a. All returns with either a deduction for insurance premiums, a deduction for extraordinary medical expenses, or both.

b. Qualifying medical expenses over 3 percent of adjusted gross income.

Table 3. (continued)

Total Tax Savings from the Deduction for Taxpayers in the Individual Income Class[c] (in Millions of Dollars)	Average Tax Increase per Claimant if the Deduction Were Repealed[d] (in Dollars)	Percent of Tax Savings from the Deduction Received by Taxpayers in the Indicated Income Class	Percent of All Tax Returns Filed With Expanded Income in Income Class
10.0	64	0.4	26.2
162.8	103	6.4	21.7
350.8	117	13.8	16.0
415.1	122	16.3	13.1
685.1	127	26.9	14.6
541.3	162	21.2	6.5
251.4	310	9.9	1.5
105.8	748	4.1	0.3
27.5	829	1.1	0.1
2,549.8	143	100.0	100.0

c. Calculated as the increase in taxes resulting from repeal of the deduction under 1979 law at 1978 income levels.

d. Estimate for calendar year 1979 at 1978 income levels.

TABLE 4. DISTRIBUTION OF TAX SAVINGS FROM THE DEDUCTION FOR EXTRAORDINARY MEDICAL EXPENSES[a]

Expanded Income Class (in Dollars)	Number of Returns Claiming the Deduction for Extraordinary Medical Expenses (in Thousands)	Aggregate Tax Savings for Taxpayers in the Indicated Income Class[b] (in Millions of Dollars)	Percent of Aggregate Tax Savings Received by Taxpayers in the Indicated Income Class	Average Tax Increase per Claimant if the Deduction Were Repealed[c] (in Dollars)
Less than 5,000	282	10.0	0.4	71
5,000 - 10,000	1,472	144.2	6.9	104
10,000 - 15,000	2,261	306.1	14.6	135
15,000 - 20,000	2,291	352.1	16.8	156
20,000 - 30,000	2,918	548.5	26.2	190
30,000 - 50,000	1,299	410 5	19.6	327
50,000 -100,000	205	203.2	9.7	1,130
100,000 -200,000	22	95.8	4.6	5,333
200,000 and over	3	25.1	1.2	11,669
All returns	10,754	2,094.3	100.0	202

SOURCE: Treasury Department tax model, 1979 tax law at 1978 income levels.

a. The deduction for qualifying medical expenses above 3 percent of adjusted gross income.

b. Calculated as the increase in tax liabilities resulting from repeal of the deduction for qualifying medical expenses above 3 percent of adjusted gross income.

c. Estimate for 1979 law at 1978 income levels.

deduction--3 percent of adjusted gross income--rises as income increases. The data indicate, though, that tax savings from the deduction are still concentrated disproportionately among the more affluent.

ANALYSIS

Tax Subsidy or Ability-to-Pay Provision?

The medical expense deduction has often been characterized as promoting taxation on the basis of a taxpayer's ability to pay. For the most part, this description rests on the assumption that medical care is largely involuntary, so that medical expenses reduce a family's "discretionary" or spendable income. Since discretionary income forms the basis of a taxpayer's ability to pay, and since the income tax is intended to reflect the ability-to-pay criterion, this assumption suggests that the medical expense deduction represents part of the "normative" tax code, rather than a subsidy grafted onto it.[6]

Although some tax analysts accept this view of the deduction, most do not. Most tax experts now consider the medical expense deduction as a tax expenditure that subsidizes a select group of taxpayers whose out-of-pocket expenditures for health insurance and medical care satisfy the statutory requirement for deductibility. One reason for this view is that more than two-thirds of all medical expenditures are now covered by health insurance or government health programs, with 90 percent of the U.S. population having either one type of coverage or both.[7] Thus, the bulk of all medical expenditures are covered by insurance, leaving the medical expense deduction to subsidize the cost of those expenditures that are not covered. The range of deductible items is nevertheless quite broad. For example, the medical deduction can be used to subsidize the cost of cosmetic surgery, expensive rest

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6. See William D. Andrews, "Personal Deductions in an Ideal Income Tax," Harvard Law Review, vol. 86 (December 1972), pp. 333-37.

7. During 1978, about 67 percent of all personal health care expenditures (medical outlays less payments for research) were provided by private insurers, the federal government, and other third-party payors. See Robert M. Gibson, "National Health Expenditures, Fiscal Year 1978," Health Care Financing Review, Vol. 1 (Summer 1979), pp. 7-8. See also CBO, Profile of Health Care Coverage, p. 1.

cures, and elaborate medical equipment in the home--items generally excluded from insurance coverage--to the extent their cost exceeds 3 percent of adjusted gross income.[8]

Problems with the Deduction as Tax Subsidy

If the medical deduction is viewed as a tax subsidy, it can be criticized for a number of shortcomings.

Perverse Distributional Pattern of Benefits. In general, the need for subsidies is considered greatest among families with the lowest incomes and decreases as income increases. Benefits provided by the medical expense deduction, however, tend to increase with income, because the percentage rate of subsidy equals the taxpayer's marginal tax rate. This holds true even though the floor for the deduction for extraordinary medical expenses is set at 3 percent of adjusted gross income and, thus, increases with taxpayer income (see Tables 3 and 4). Furthermore, because tax savings are available only to taxpayers who itemize their deductions, the medical expense deduction provides no benefits to the roughly 72 percent of all taxpayers who do not itemize deductions--although many taxpayers with very high out-of-pocket medical expenditures do use the deduction. For some low-income taxpayers, this gap in coverage does not present a problem, because other government programs such as Medicare and Medicaid provide significant subsidies for medical care. Nevertheless, between 4.4 and 4.9 million persons in households with incomes below $5,000 have no form of public or private health care coverage.[9] For these persons, and for many households with incomes between $5,000 and $15,000 and only limited health insurance coverage, neither the medical expense deduction nor any direct

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8. See, for example, Henri C. Pusker, "The Changing Scope of Medical Expense Deductions," Taxes, vol. 57 (June 1979), pp. 347-353. Note, however, that current law limits the deductibility of capital expenditures for health care, such as the cost of installing an elevator, to the difference between the cost as installed and the resulting increase to the value of the property where the item is installed.

9. These estimates are based on figures in CBO, Profile of Health Care Coverage, Table 4, p. 16.

expenditure government assistance program provides significant protection against high medical expenses.

Low Rates of Subsidy. Because the subsidies provided by the deduction depend on the taxpayer's marginal tax rate, rates of subsidy per dollar of qualifying expenditures are relatively low. Marginal tax rates under the federal income tax range from 14 to 70 percent. Moreover, two-thirds of all tax returns for calendar year 1978 had marginal tax rates of 30 percent or less. At these levels, few taxpayers receive even a 50 percent reimbursement for their deductible expenses. Thus, the deduction provides few households with much coverage against large, uninsured medical expenses.

The Time Lapse Between Expenses and "Reimbursement." Another problem with the deduction as a subsidy, or reimbursement, for extraordinary medical expenses is that the full tax saving from the deduction may not come until long after the expenses are incurred. Under current tax laws, any taxpayer with extraordinary medical expenses can obtain some tax savings soon after the expenses are incurred by reducing the amount of income tax withheld.[10] The withholding system, however, cannot immediately compensate for large medical expenses, because negative withholding is not allowed and tax savings from additional deductions are normally spread over the entire tax year. A taxpayer with large expenses early in the year may be able to recover most of that within a few months. If outlays come later, substantial reimbursement cannot come until the year's tax return is filed and a refund is received.[11]

Other Problems with the Medical Deduction

In addition to the problems associated with its role as a tax subsidy, the current medical expense deduction has other disadvantages.

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10. The tax laws permit taxpayers with itemized deductions to claim extra withholding exemptions.

11. See General Accounting Office, "Inequities in the Federal Withholding Tax System," Report to the Congress by the Comptroller General of the United States (December 2, 1977).

High Rates of Error by Taxpayers. The medical expense deduction is one of the most important sources of taxpayer error in the tax code. A study conducted by the IRS of tax returns for 1973, for example, indicated that more than 75 percent of the 13,600 returns examined contained some type of mistake in calculating the medical expense deduction--a higher rate of error than for any other item surveyed. Another IRS survey of tax returns filed during 1977 revealed that the medical deduction was among the five tax code items with the highest error rates.[12]

The errors involved in claiming the deduction generally fall into two categories: issues of definition and problems of computation. Issues of definition arise because it is often difficult to distinguish "medical" from "nonmedical" expenses. For example, taxpayers may usually deduct the cost of travel to a warmer climate prescribed by a physician, but not the cost of food and lodging while there.[13] Computational difficulties result because the tax code requires separating actual medical expenses from payments toward health insurance premiums and keeping separate account of drug purchases. Although the tax form simplifies the procedure by breaking it down into steps, the entire operation remains very complex. In addition, the current tax form complicates matters by requiring the taxpayer to combine the health insurance deduction calculated on one line with the deduction for extraordinary medical expenses, which is calculated several lines below. The IRS studies cited earlier suggest that the error rate might be substantially less if the two deduction items were listed instead as separate deductions.

Low Visibility and Controllability of Expenditures. Tax losses resulting from the medical expense deduction suffer from low visibility in much the same way as those caused by the employer exclusion discussed in Chapter II. Because the deduction

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12. See letter from IRS Commissioner Jerome Kurtz to John S. Nolan, December 27, 1977, distributed at the American Law Institute-American Bar Association Conference on Federal Income Tax Simplification, Warrenton, Virginia, January 4-7, 1978.

13. For more discussion, see Richard Goode, The Individual Income Tax, revised ed. (Brookings Institution, 1976), pp. 158-59.

is a permanent part of the tax code, the revenue losses it creates are not subject to regular Congressional review. Thus, the visibility of expenditures from the deduction is much less than that of most direct expenditure programs. In addition, revenue losses from the deduction are uncontrollable, because the deduction creates open-ended, individual entitlements to tax savings.

Upward Effect on Medical Spending. By offsetting a portion of out-of-pocket medical expenses and the cost of individual-paid health insurance, the deduction encourages additional medical spending. Taxpayers benefiting from the deduction have less incentive to economize on medical services or to consider price in choosing providers, because each dollar of deductible expenses is subsidized. Thus, taxpayers are encouraged to increase medical expenditures. Similarly, the subsidy for individual-paid health insurance gives additional incentives to acquire more extensive coverage. This added coverage, in turn, further stimulates medical spending because insurance itself lowers the out-of-pocket medical care.

The overall effect of the deduction on medical spending is probably small, because few taxpayers receive a sizable percentage of out-of-pocket expenses from the deduction and most would still have health insurance even without the savings the deduction provides. Nevertheless, the subsidies provided by the deduction may have some effect on upper-income taxpayers, for whom the deduction can provide significant reductions in the cost of elective, uninsured care.

Interaction of the Deduction with Health Insurance

As indicated earlier, the medical deduction helps to reimburse the cost of uninsured services, while health insurance reduces the amount of medical expenses qualifying for the medical deduction. Where outlays for necessary uninsured services are concerned, the ability of the deduction to subsidize uninsured medical expenses promotes taxation on the basis of taxpayers' ability to pay. However, the deduction can also subsidize the cost of elective medical items not generally covered by insurance, such as cosmetic surgery and elaborate physical examinations. In these cases, the deduction serves more to promote consumption of medical care than to fill important gaps left by private health insurance. In addition, the benefits are often provided to those

who can afford care in their own right rather than to those who would not have care available without the deduction.

ALTERNATIVES TO THE PRESENT DEDUCTION

If the Congress wishes to change the present deduction, many options are available. One possibility, for example, would be to revive Section 112 of the House version of the Revenue Act of 1978. This would have eliminated both the separate deduction for insurance premiums and the 1 percent floor on drug and medicine purchases.[13] These changes would simplify the deduction and reduce its inflationary consequences. At the same time, they would revive any disincentives to acquiring health insurance that might have existed under the law before 1965. Perhaps more important, these changes would broaden the current disparities between taxpayers with and without employer-subsidized plans. This last point is worth mentioning, because the separate deduction of premiums is the only subsidy for health insurance available to many persons with individual-paid health plans.[14]

More far-reaching alternatives than simplifying the deduction could also be considered. For example, to provide taxpayers at all income levels with the same rate of subsidy, the deduction could be converted to a "refundable" or "nonrefundable" flat-rate tax credit. A refundable credit would make subsidies available to nontaxpayers and to persons whose taxable incomes were less than the amount of the credit. A non-refundable credit, however, would

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13. Implementing this proposal would have reduced federal revenues by about $16 million in fiscal year 1979 and $43 million in fiscal year 1980, according to estimates by the Joint Committee on Taxation. By contrast, eliminating only the separate deduction for health insurance premiums and instead counting all premium payments toward the deduction for extraordinary expenditures would raise federal revenues by about $236 million at 1978 income levels, largely because the floor on deductible drug expenses would be retained.

14. Without the separate deduction, individual payments for health insurance premiums would be deductible only to the extent that qualifying out-of-pocket medical expenditures exceeded 3 percent of adjusted gross income.

make savings available only to persons with net taxable incomes. To reduce the cost of the deduction and eliminate subsidies for out-of-pocket medical expenses normally incurred by taxpayers at various income levels, the current floor for expenses that qualify for the deduction could be set at a higher percentage of adjusted gross income than the current 3 percent level. Alternatively, it could be changed to a fixed dollar amount based on family size and composition. Finally, the federal government could provide, or require all U.S. residents to have, catastrophic health insurance. Three specific alternatives are explained here: changing the deduction to a tax credit, raising the floor for deductible expenses, and replacing the deduction with government-financed catastrophic health insurance.

Changing the Deduction to a Tax Credit for Extraordinary Medical Expenses

Changing the medical expense deduction to a tax credit for extraordinary medical expenses could eliminate many of the present distributional inequities in the deduction. A nonrefundable tax credit would make subsidies available to all net taxpayers, including those who do not itemize deductions, while a refundable credit would provide benefits to households with incomes too low to incur positive tax liabilities as well. Changing the deduction to a tax credit would also eliminate the tendency for benefits to rise with taxpayer income, especially if the credit involved a fixed percentage of all qualifying expenditures and the credit itself were not taxable.[15] Table 5 indicates the changes in tax liabilities that would result from converting the medical deduction to a 25 percent refundable tax credit for medical expenses above 3 percent of adjusted gross income.

Replacing the deduction with a tax credit would have some disadvantages. First, revenue losses from the credit could be much higher than for the deduction if the rate of credit were at all sizable, because many more taxpayers could become entitled to

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15. If the credit were made taxable, the subsidy would become progressive--that is, higher-income taxpayers would receive lower subsidy rates--since the tax paid on the credit would be higher for taxpayers in higher marginal tax brackets.

TABLE 5. EFFECT ON TAX LIABILITIES OF REPLACING THE DEDUCTION FOR EXTRAORDINARY MEDICAL EXPENSES WITH A REFUNDABLE 25 PERCENT TAX CREDIT FOR MEDICAL EXPENSES ABOVE 3 PERCENT OF ADJUSTED GROSS INCOME: BY INCOME CLASS

	Taxpayers Experiencing a Tax Decrease			
Expanded Income Class (in Dollars)	Number of Returns (in Thousands)	Percent of Total Returns in Income Class	Amount (in Millions of Dollars)	Average Decrease (in Dollars)
Less than 5,000	2,053	8.9	-191	-95
5,000- 9,999	1,885	9.8	-371	-197
10,000- 14,999	1,154	8.1	-223	-193
15,000- 19,999	648	5.6	-97	-150
20,000- 29,999	251	1.9	-57	-226
30,000- 49,999	15	a	-6	-385
50,000- 99,999	1	a	a	-647
100,000-199,999	a	a	a	-365
200,000 and over	a	a	a	-6,309
All Incomes	6,007	6.8	-945	-157

(continued)

SOURCE: Treasury Department tax model, 1979 tax law at 1978 income levels.

Table 5. (continued)

Taxpayers Experiencing a Tax Increase				
Number of Returns (in Thousands)	Total Returns in Income Class	Amount (in Millions of Dollars)	Average Increase (in Dollars)	Net Tax Change (in Millions of Dollars)
17	a	0	27	-190
632	3.3	14	23	-356
1,617	11.4	66	41	-157
1,914	16.5	120	63	23
2,748	21.3	276	101	219
1,248	21.9	273	219	267
179	13.4	140	783	140
18	6.8	66	3,665	66
2	3.1	19	9,377	19
8,375	9.5	975	116	30

a. Less than 0.5.

the tax savings.[16] Remedying this problem would require either setting a low rate of tax credit or limiting the credit to a much smaller set of medical expenditures, such as all outlays over 10 or 15 percent of adjusted gross income. Second, with more taxpayers entitled to tax savings, the demand for health care might rise, thereby contributing to inflation. In addition, some families would experience tax increases. Furthermore, establishing a tax credit for medical expenses would also require the Congress to decide whether the resulting tax savings should themselves be taxed. This is a difficult question to resolve, since some federal tax subsidies (the targeted employment tax credit, for example) are taxed, while others (such as the investment tax credit) are not.

Besides these drawbacks, changing the deduction to a tax credit would leave many other problems of the present deduction intact. For example, moving to a tax credit would do nothing to shorten the time lag in receiving benefits, since reimbursements would still be limited either to increased withholding exemptions or to refunds after tax returns are filed. Adopting a credit would also leave the visibility problem unsolved, since the benefits would still result from permanent provisions in the tax law and hence would not be subject to regular review. Likewise, controllability would remain a problem, because the benefits would still be entitlements. Furthermore, the change would not simplify the job of claiming and administering benefits. If anything, moving to a tax credit could increase the difficulties for both taxpayers and the IRS, since taxpayers would have to calculate a tax credit in addition to the total of their medical outlays, and the IRS would have many more returns to check for medical expense claims.

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16. The Treasury Department's tax model suggests otherwise (see Table 5). However, the figures on which the model's estimate is based do not include the medical expenses of persons who do not file tax returns, although medical expenses are imputed for persons who file returns but do not now claim the medical expense deduction. Since many non-filers are elderly persons with low taxable incomes and high medical expenses, the Treasury's approach may underestimate the volume of medical expenses among nontaxpayers who might file returns to

Raising the Threshold for Subsidized Medical Outlays

Another way of changing the medical deduction would be to raise the threshold or floor for subsidized expenses from 3 percent of adjusted gross income to some higher level such as 5 percent. This change could be instituted either by itself or along with changing the deduction to a tax credit. Raising the threshold for subsidized medical expenses could help remedy the distribution problem of the tax subsidy. The deduction, however, might then no longer subsidize all "extraordinary" expenses, since the average household appears to spend about 3.9 percent of its income for out-of-pocket medical expenses.[17] Raising the threshold would also lower the cost of the tax provision. For example, keeping the subsidy a deduction but returning the threshold for deductible expenses to its pre-1954 level of 5 percent of adjusted gross income would reduce revenue losses by about $765 million at 1978 income levels (see Table 6).

Raising the minimum for subsidized expenses, like changing the deduction to a tax credit, would not eliminate all the disadvantages of the present medical deduction. For example, a deduction or tax credit with a higher floor would still mean significant delays for taxpayers in claiming benefits. Moreover, revenue losses would be neither more visible nor more controllable. In addition, raising the floor would do nothing to change the tendency of subsidies to rise with taxable income. A higher threshold would, however, reduce the effective rate of subsidy as a whole, since a smaller fraction of medical outlays would qualify

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claim a refundable tax credit for high medical expenses. This, in turn, could lead to an underestimate of the loss in revenues from converting the medical expense deduction to a refundable tax credit.

17. This figure was obtained by multiplying a recent estimate of medical expenditures as a percent of adjusted gross income (7.2 percent) by the estimated percentage of total consumer medical expenditures represented by out-of-pocket payments in 1976 (54 percent). See Steuerle and Hoffman, "Tax Expenditures for Health Care," p. 9; and Marjorie S. Carroll, "Private Health Insurance Plans in 1976: An Evaluation," Social Security Bulletin, vol. 41 (September 1978), p. 14.

TABLE 6. EFFECT ON TAX LIABILITIES OF RAISING THE MINIMUM DEDUCTION FOR EXTRAORDINARY MEDICAL EXPENSES TO 5 PERCENT OF ADJUSTED GROSS INCOME: BY INCOME CLASS

Expanded Income Class (in Thousands)	Decrease in Number of Taxpayers Claiming Medical Deduction (in Thousands)	Number of Taxpayers Experiencing Tax Increase (in Thousands)	Taxpayers Experiencing a Tax Increase as a Percent of all Taxpayers in Income Class	Aggregate Increase in Tax Liabilities to All Households in Income Class (in Millions of Dollars)	Average Increase in Taxes to Households in Income Class Experiencing an Increase (in Dollars)
Less than 5,000	5	66	0.3	1	12
5,000- 10,000	123	1,220	6.3	28	23
10,000- 15,000	316	2,155	15.2	83	39
15,000- 20,000	374	2,252	19.5	125	55
20,000- 30,000	523	2,890	22.4	235	81
30,000- 50,000	150	1,296	22.7	195	151
50,000-100,000	23	204	15.2	71	347
100,000-200,000	2	22	8.3	20	914
200,000 and over	1	3	4.6	8	2,184
All Returns	1,516	10,108	11.4	765	76

SOURCE: Treasury Department tax model, 1979 tax law at 1978 income levels.

for tax benefits. Thus, many taxpayers would find themselves with higher tax liabilities.

To minimize the effect of a higher floor for taxpayers with very high out-of-pocket medical expenses, the new minimum could be paired with special credits for medical expenses above a still higher fraction of adjusted gross income. For example, taxpayers with large medical outlays could be given a tax credit for medical expenses above a secondary minimum, such as 10 percent of adjusted gross income, in addition to a deduction for all medical expenses above 5 percent of adjusted gross income. Adding such a credit to a higher basic threshold would, of course, increase the cost of the deduction. For example, a nonrefundable 25 percent tax credit for itemized medical expenses above 10 percent of adjusted gross income would raise the cost of a deduction with a floor of 5 percent by about $429 million at 1978 income levels, according to the Treasury Department's tax model. A refundable tax credit with the same provisions, by contrast, would increase the cost by $967 million.[18]

Replacing or Supplementing the Deduction with a Direct Expenditure Program Providing Catastrophic Health Insurance

A third option for changing the medical deduction would be to supplement or replace the deduction with government-provided insurance against catastrophic health expenses--outlays exceeding either a certain dollar amount or a certain fraction, such as 10 percent, of household income.[19] The sharp rise in medical costs during the last few years has given increasing impetus to the drive for a catastrophic health insurance program, and bills to establish catastrophic health coverage have been introduced both in the present and in previous sessions of Congress.[20]

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18. Treasury Department tax model, 1979 tax law at 1978 income levels.

19. This section provides only a brief analysis of catastrophic health insurance as an alternative to the medical expense deduction. For a more general analysis see Congressional Budget Office, Catastrophic Health Insurance, Budget Issue Paper (January 1977).

20. See the following bills that were introduced in the first session of the 96th Congress: "Catastrophic Health Insurance

A catastrophic health insurance program could cost several times as much as the current medical expense deduction, in large part because many more persons would be eligible for subsidies.[21] Such a program would, however, cover many low- and moderate-income households that do not now benefit from the deduction and cannot qualify for direct assistance programs such as Medicaid and Medicare. In addition, catastrophic health insurance would target federal expenditures on a small but particularly important portion of all medical outlays. Thus, a much higher percentage of catastrophic medical costs could be reimbursed than is now possible with the medical expense deduction. Such a program would also greatly improve the visibility of federal subsidies for extraordinary medical expenses.

One distinct problem with catastrophic health insurance--and for that matter, with a generous tax credit for catastrophic health expenditures--is that it could increase total medical expenditures, whether the insurance was provided by the federal government or by employers. Both approaches would reimburse all or nearly all medical expenditures above the level established in the legislation. Thus, neither patients nor health-care providers would have much incentive to avoid unnecessary or marginally valuable services once the specified level of expenditures was reached. Another potential drawback is that revenue losses from the employer exclusion (see Chapter II) would increase if the system were created through mandatory employer-paid coverage.[22] Revenue losses from the exclusion would decrease, however, if coverage resulted from a government-funded program, since employers would not have to provide insurance against catastrophic expenses through their own policies.

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and Medical Assistance Reform Act," S. 350, introduced by Senators Russell Long and Abraham Ribicoff; "Catastrophic Health Insurance and Medicare Improvements Act of 1979," S. 748, introduced by Senators Robert Dole, John Danforth, and Pete Domenici; and "A Bill to Amend the Social Security Act," S. 760, introduced by Senator Long.

21. See, for example, CBO, Catastrophic Health Insurance.

22. This approach might require low-wage firms to be subsidized to prevent layoffs from occurring.

Perhaps the biggest effect catastrophic health insurance would have on the deduction is that it would change the character of the deduction. Under catastrophic health insurance, the medical deduction would no longer serve as a tax offset for all above-average out-of-pocket medical expenses. Instead, the deduction would subsidize only those expenses between 3 percent of adjusted gross income and the level at which catastrophic health insurance took effect. With catastrophic health insurance, the medical deduction would become something of a supplementary health insurance plan, providing more limited support for expenditures too low to qualify as catastrophic but high enough to exceed what is considered a normal level of outlays. Thus, the role of the deduction as a supplement to health insurance coverage might become more evident if catastrophic health insurance were introduced.

CHAPTER IV. TAX-EXEMPT FINANCING FOR PRIVATE HOSPITAL PROJECTS

The third major tax expenditure for health care results from the use of tax-exempt bonds to finance capital projects undertaken by hospitals and other private medical institutions. These bonds are commonly issued by state or local development authorities on behalf of public or private institutions serving designated functions. Thus, they are to a considerable extent subject to state or local government control, although they create federal revenue losses and are subject to some federal restrictions.[1] Under Section 103 of the Internal Revenue Code, tax-exempt bonds may be issued for tax-exempt hospitals to cover the cost of construction, remodeling, and other capital projects. Proprietary (for-profit) hospitals may also benefit from tax-exempt bonds under the so-called "small issue" exemption in Section 103 for industrial revenue bonds. In fiscal year 1980, these bonds could cost the federal treasury about $400 million in foregone revenues.[2]

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1. See, for example, Internal Revenue Code Section 103.

2. This revenue estimate should be regarded as tentative, because it relies heavily on five assumptions. First, more than $15.4 billion in tax-exempt hospital bonds are expected to be outstanding by 1980 based on estimates of bond issues and refundings from 1971 (the first year these bonds were issued in any significant volume) through the third quarter of 1979. Second, tax-exempt financing is assumed to generate no additional capital spending by hospitals (if additional spending is generated, the revenue loss would be higher). Third, tax-exempt financing is assumed to displace primarily taxable financing from other sources rather than consumption, saving, or other tax-exempt financing. This displacement of taxable issues results from a chain reaction among investors in which each investor moves down a rung on a ladder of securities ranging from fully taxed at the top to tax-exempt. The net result is equivalent to having tax-exempt issues displace fully taxable ones in the market, even though no individual investor moves directly from tax-

Although tax-exempt hospital bonds do not result in so large a tax expenditure as the medical expense deduction or the employer exclusion, they are important because of their role in financing hospital construction. Between 1976 and 1978, these bonds provided between one-third and one-half of all funds for hospital construction in the United States. In 1979, more than half the funding for construction could come from tax-exempt bonds (see Table 7).[3] Studies also indicate that tax-exempt bonds are important in financing construction at private, as well as public, hospitals. An annual survey of hospital construction activities by the American Hospital Association, for example, indicated that, among responding hospitals, tax-exempt bonds funded 47.5 percent of all construction at short-term non-federal hospitals and 49.2 percent of the construction undertaken at short-term private not-for-profit hospitals during 1977.[4] These levels all represent a sharp increase from the proportion of funds provided by tax-exempt bonds before 1975.

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exempt to fully taxable investments. The fourth assumption is that the interest rate on displaced taxable investments averages 9 percent. This is probably a conservative estimate, given current market rates on commercial loans and high-grade corporate bonds. Finally, the marginal tax rate of the average net purchaser of tax-exempt securities is assumed to equal 30 percent, based on Treasury Department studies.

If 95 percent of the financing displaced by tax-exempt bonds is taxable and the remaining sum is tax-exempt, these assumptions imply that the annual revenue loss to the federal government from tax-exempt hospital bonds would be about $395 million ($15.4 billion x 0.95 x 0.30 x 0.09 = $395.3 million.) The revenue loss would increase further with the issuance of additional tax-exempt hospital bonds during 1980.

3. See also Hospital Financing Study Group and ICF, Inc., "Recent Trends in Financing Health Facility Construction," August 1978.

4. See "Sources of Funding for Construction," Hospitals, vol. 53 (February 16, 1979), pp. 63-71, reprinted in AHA Research Capsule No. 29.

TABLE 7. TAX-EXEMPT BONDS AS A SHARE OF TOTAL HOSPITAL CONSTRUCTION FUNDING, 1971-1979, IN MILLIONS OF DOLLARS

Year	Volume of Tax-Exempt Hospital Bonds Issued[a]	Volume of Bonds Net of Refundings	Net Proceeds Used for Hospital Construction[b]	Net Proceeds as a Percent of all Hospital Construction
1971	262.0	262.0	222.7	5.8
1972	525.0	525.0	446.2	10.7
1973	610.6	610.6	519.0	12.5
1974	1,282.4	1,282.4	1,090.0	24.5
1975	1,959.0	1,861.1	1,581.9	31.9
1976	2,725.6	2,453.4	2,085.0	39.5
1977	4,731.5	2,971.4	2,525.7	50.3
1978[c]	3,121.8	2,338.7	1,987.9	38.5
1979	3,153.5[d]	3,106.7[d]	2,640.7[d]	52.0[e]

SOURCES: The Bond Buyer; ICF, Incorporated; Hospital Financing Study Group; American Hospital Association; and U.S. Bureau of the Census, Construction Reports, Volume of New Construction Put in Place, Series C30, Nos. C3078-5 (May 1978) and C30-79-8 (August 1979).

a. Excludes some small issues not reported by The Bond Buyer.

b. Funds available after excluding refinancing issues and assumed non-construction uses of funds. ICF, Inc. estimates that, on average, only about 85 percent of all tax-exempt bond proceeds are available for construction purposes.

c. Includes some issues for nursing homes.

d. Annual estimate based on first nine months.

e. Estimate based on projections of annual construction for the first eight months of 1979.

The History of Federal Subsidies for Hospital Construction

The large increase in the proportion of funds provided by tax-exempt bonds has coincided with a substantial reduction in direct federal government subsidies since the mid-1970s. Before 1974, direct expenditure programs were far more important than tax-exempt bonds in financing hospital projects, because large subsidies were available through the Hill-Burton program for hospital construction.[5] In 1974, however, the authority for funding loans, grants, and loan guarantee projects was shifted to a new program, created in Title XVI of the Public Health Service Act, by the passage of the National Health Planning and Resources Development Act (Public Law 93-641).[6] This legislation imposed tight new restrictions on the development of new hospital facilities, in part because of a belief that existing federal programs had promoted inflation in the health-care sector.[7]

The use of funds under the Title XVI program has been limited by the failure of states to satisfy the health-planning requirements set out in Title XV of the act and by the failure of the Department of Health, Education, and Welfare (HEW) to issue final regulations. In addition, Congressional funding for the entire Title XVI program, including projects at state and local government hospitals, has been limited to an increase in federal loan authority of $250 million in 1977, none of which had been allocated as of September 1979. At present, loans and grants are being made primarily to allow medical facilities to

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5. The Hill-Burton program, established in 1946, provided significant subsidies for constructing hospitals in many parts of the United States where hospital facilities were limited.

6. For a detailed analysis of this act, see Kay Cavalier, "The National Health Planning and Resources Development Act--Summary of Existing Law and Its Implementation," Congressional Research Service, No. 77-50 ED. (1977).

7. See the National Health Planning and Resource Development Act, P.L. 93-641, Section 2(a)(2), 42 U.S.C. §300K (a)(2) (1975).

correct safety hazards and to avoid noncompliance with licensing or accreditation requirements. Most other payments are limited to developing facilities for ambulatory patient care and to converting inpatient facilities to outpatient use.

The one direct federal expenditure subsidy for general hospital construction now readily available is the provision of mortgage insurance through the Section 242 program administered by the Department of Housing and Urban Development (HUD). (At the time of publication of this paper, however, very few hospitals were taking advantage of the financing available under Section 242.) Hospitals in rural areas (places with populations under 10,000) with no other sources of funds can obtain low-interest, long-term loans through the Farmers Home Administration (FmHA) of the Department of Agriculture. In addition, the Appalachian Regional Commission and the Department of Commerce's Economic Development Administration (EDA) will provide limited subsidies to medical institutions in areas that qualify for assistance from these agencies. Apart from these programs, however, most direct federal subsidies for medical capital projects have been eliminated. Thus, tax-exempt bonds have become the major largely unrestricted government program for subsidizing capital projects at private hospitals and medical facilities.

LEGISLATIVE HISTORY AND MECHANICS

Before 1968, any hospital project in the United States could theoretically use tax-exempt bonds to finance capital projects, because the tax code did not prohibit the use of industrial development bonds for nonexempt, for-profit institutions and organizations. Before that year, any hospital that successfully applied to a state or local industrial development bond (IDB) authority empowered to issue hospital bonds could have tax-exempt bonds issued on its behalf. In addition, in states where IDB authorities did not exist, or where they were not permitted to issue bonds for hospital projects, tax-exempt hospitals could, in theory, issue these securities themselves if they complied with the requirements of IRS Revenue Ruling 63-20. This ruling allowed institutions to issue tax-free bonds "on behalf of" state or local governments if title to the financed

project would pass to a state or local government upon completion of the project and if certain other conditions were met.[8]

In 1968, the rules regarding tax-exempt bonds were changed by the addition of Section 103(b) to the Internal Revenue Code. Under this provision, taxable institutions, which include proprietary medical institutions, were prohibited from issuing more than $5 million in tax-exempt bonds during any six-year period.[9] No new restrictions, however, were imposed on the use of tax-free bonds by tax-exempt hospitals.

Under current law, not-for-profit hospitals thus have a variety of ways to obtain tax-exempt financing for projects. Using sections 103(a) and (b) of the Internal Revenue Code and Revenue Ruling 63-20, these hospitals may still issue bonds themselves, "on behalf of" state and local governments, according to the terms stated above. In at least 47 states, however, state or local government tax-exempt financing authorities are authorized to issue tax-exempt bonds for private hospitals.[10]

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8. See Revenue Ruling 63-20, IRS Cumulative Bulletin, 1963, vol. 1, p. 24.

9. See Section 103(b)(6). The $5 million limit was increased to $10 million by the Revenue Act of 1978.

10. As of November 1979, only two states--Alaska and Hawaii--did not have statutes authorizing this type of financing. In Missouri, however, this type of financing was withheld until recently because the statute authorizing it had been challenged as unconstitutional. The statute has since been upheld, and bonds were issued earlier this year. The state of Washington statute for hospital bond financing has been under similar attack; that case, however, had not yet been decided when this paper was published. Sources for the above information: Blyth, Eastman, Dillon Health Care Funding, Inc., "A Brief Introduction to Health Care Capital Financing Alternatives," paper presented at the National Health Policy Forum, September 11, 1978; and conversations with bond financing staff at Kidder-Peabody, Inc. and staff at The Bond Buyer.

This option, which avoids the need to place title in a state or local government, is now the predominant form in which tax-exempt hospital bonds are issued. For proprietary hospitals, tax-exempt financing is limited to small issues not exceeding $10 million. Thus, tax-exempt bonds are available primarily for use by tax-exempt, nonprofit institutions.

ANALYSIS

Are Federal Subsidies for Hospital Construction Needed Under Present Conditions?

In analyzing tax-exempt hospital bonds, a critical question is whether federal subsidies for hospital construction are still needed. In the past, government subsidies to private, not-for-profit hospitals have been justified because of a shortage of hospital beds in many parts of the United States, particularly rural areas. A growing number of researchers, however, have come to believe that the United States now has an excess of hospital beds. Several studies have appeared arguing that hospital bed occupancy levels, which have averaged 75 percent for the nation as a whole during recent years, could generally be raised to 80 or 85 percent without lowering the quality of medical care.[11] There is also information to suggest that current hospital utilization is excessive, implying that hospital bed capacity could be reduced still further without impairing the quality of care. Established HMOs, for example, generally use 30 to 50 percent fewer hospital days and only half the number of hospital beds as do fee-for-sevice providers for similar groups of patients.[12] In addition, many researchers have found that areas with more hospital beds per capita have

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11. See, for example, Walter McClure, Reducing Excess Hospital Capacity (Excelsior, Minn.: InterStudy, October 1976); and National Academy of Sciences, Institute of Medicine, Controlling the Supply of Hospital Beds (Washington: October 1976).

12. See McClure, Reducing Excess Hospital Capacity.

higher rates of hospital utilization,[13] suggesting that the supply of hospital beds to some extent creates its own demand.

Although many parts of the United States are considered deficient in health care resources, most recent studies have identified shortages of medical personnel--doctors and nurses--as the reason.[14] Thus, the consensus of available research would suggest that the United States as a whole has an excess of hospital beds. Individual areas, however, may well have shortages of hospital beds or other capital equipment. Current health-planning regulations would allow subsidies to be targeted to hospitals in these areas, since the regulations require virtually all hospital projects to undergo review before being built.[15] There is some question, however, whether these rules are working in the desired way. This issue will be discussed further in the next section.

Special Problems with Tax-Exempt Bonds as a Subsidy

Although hospital subsidies in general have been questioned because of the number of unoccupied hospital beds, the current tax-exempt bond provisions have some special difficulties as a way of subsidizing hospital projects. Some of these difficulties deserve particular mention.

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13. McClure, Reducing Excess Hospital Capacity, contains a review of the liteature on this subject.

14. See General Accounting Office, "Progress and Problems in Improving the Availability of Primary Care Providers in Underserved Areas," HRD 77-135, August 22, 1978; U.S. Department of Health, Education, and Welfare, Report to the Congress on the Status of Health Professions Research in the United States, HRA 78-93, (August 1978); and Institute of Medicine, Manpower Policy for Primary Health Care (National Academy of Sciences, May 1978).

15. For a discussion of recent trends in federal health planning activities, see Cavalier, "National Health Planning and Resources Development Act," and Congresssional Research Service, "Health Planning Amendments," Issue Brief No. IB78010 (1977).

High Cost of Delivering Funds to Hospitals. Tax-exempt bonds are sometimes considered an efficient way of delivering funds to hospitals because financing can often be arranged much more quickly than would be possible if hospitals had to apply directly to a federal agency for support. These savings in time, however, come at a price: a much smaller percentage of the total subsidy goes to the intended beneficiaries--hospitals. Most studies of tax-exempt bonds show that the federal government loses more in tax revenues than the issuing institutions receive in interest savings. Most of the difference accrues to bond purchasers, who receive a higher yield on tax-exempt issues than they need to be willing to purchase the bonds. (The extra yield arises because the interest rate for tax-free bonds is set by the marginal bond buyer who, as a rule, is in a lower tax bracket and thus requires a higher yield than other purchasers to find tax-free bonds attractive.) The remaining difference goes to compensate bond underwriters, lawyers, and others (including state bond-issuing authorities) whose services are needed to arrange for tax-exempt financing. Although no estimates of the difference between interest rate savings and federal revenue losses are available specifically for tax-exempt hospital bonds, estimates for tax-exempt bonds in general put the excess at 25 to 50 percent of total revenue losses.[16] This amount is far more than the approximately 2 to 3 percent of all funds allocated to administrative costs under the Hill-Burton program during 1969 and 1970, the last two years of extensive loan guarantee activities.[17]

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16. The Senate Budget Committee estimates that it costs the federal government $1 to provide 75¢ of interest savings to institutions issuing tax-exempt bonds. See Senate Budget Committee, Tax Expenditures, 95th Cong., 2nd Sess., 1978, p. 182. Other analysts report higher estimates of the lost subsidy. George F. Break and Joseph A. Pechman, in Federal Tax Reform: The Impossible Dream? (Brookings Institution, 1975), p. 54, estimate the differential between revenue losses and interest savings at 25 to 30 percent. Richard Goode, in The Individual Income Tax, revised ed. (Brookings Institution, 1976), p. 136, suggests that the differential may run from 33 to 50 percent of all revenue losses.

17. See Appendix to the Budget of the United States Government, 1971, p. 386, and 1972, p. 402.

Difficulty of Targeting Funds to Needed Projects. A second problem with tax-exempt bonds is that the savings they yield are hard to target on needed projects. On the one hand, tax-exempt funds are available only to hospitals that can sell tax-exempt bonds. This restriction prevents subsidizing some worthy projects, because hospitals with a large proportion of uninsured, low-income patients often have trouble selling bonds. On the other hand, tax-exempt bonds can be used to finance projects that, objectively, may be unnecessary. All states, in accordance with the Health Planning and Resources Development Act, have extensive health-planning systems, and hospital projects cannot be begun without state-issued certificates of need. These regulatory mechanisms, however, appear to have important weaknesses. In some states, for example, planning agencies are dominated by industry representatives, and some have been overruled by the actions of the state legislature.[18] Moreover, according to several studies, the certificate-of-need program has not lowered costs or restrained the growth of hospital capital projects, although there has been some decrease in construction of new beds and an offsetting rise in other capital expenditures.[19] These findings are not conclusive, but since the certificate-of-need process is the primary means for preventing unnecessary hospital projects from receiving tax-exempt financing, the evidence suggests that tax-exempt bonds may still subsidize some projects of doubtful need.

Creation of Tax Inequities. A third problem with tax-exempt bonds as a subsidy for hospital projects is that they introduce distortions and inequities into the tax code. Because tax-exempt bonds provide a way of sheltering income from tax,

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18. See Elizabeth Wehr, "Health Planning Bills: Committees Back Off, Decide Not to Force Hospital Closings Now," Congressional Quarterly, June 17, 1978, pp. 1540-1543.

19. See David S. Salkever and Thomas W. Bice, Hospital Certificate-of-Need Controls (Washington, D.C.: American Enterprise Institute for Public Policy Research, 1979), especially Chap. 4. See also Frank Sloan and Bruce Steinwald, "Effects of Regulation on Hospital Cost and Input Use," paper presented at the Annual Meeting of the American Economic Association, Chicago, Illinois, August 29, 1978.

their use enables taxpayers with equal incomes to pay different amounts of income tax. Tax-exempt bonds also reduce the progressivity of the income tax, because tax savings rise with taxpayer income, and tax-exempt bondholdings among individuals are concentrated among taxpayers with high incomes.

Low Visibility and Controllability of Expenditures. A fourth problem with tax-exempt bonds is that, as with the employer exclusion and the medical expense deduction, the expenditures they create have low visibility and controllability. As tax expenditures, revenue losses from tax-exempt bonds have low visibility, because they do not appear in budgetary outlay totals. Moreover, because the tax savings result from a permanent part of the tax code, revenue losses from tax-exempt bonds do not require formal Congressional approval each year and are thus uncontrollable.

Other Considerations

Tax-exempt bonds provide federal subsidies without requiring hospitals to submit plans for federal review and possible disapproval. To qualify for tax-exempt financing, however, the projects generally require the approval of several state and local authorities. In addition, federal health planning regulations require most projects to qualify for a certificate-of-need from the relevant state health planning and development agency (SHPDA).[20] Thus, hospitals using tax-exempt financing face not an absence of red tape, but a different set of hurdles for receiving federal subsidies. Many financial analysts, however, believe that these obstacles can be circumvented more quickly than would be the case with a direct expenditure program to subsidize hospital construction.

Another point to consider in evaluating tax-exempt hospital bonds is their effect on total medical spending. Tax-exempt bonds are often thought to reduce medical costs by allowing

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20. For an explanation of the certificate-of-need program, see Cavalier, "National Health Planning and Resources Development Act," pp. 23-24. Note, however, that some states have since revised their certificate-of-need statutes to comply with the standards set forth by HEW.

institutions to finance capital projects at below-market interest rates. They can, however, also raise medical spending in certain situations. If construction subsidies lead to new facilities or equipment, for example, the resulting increase in resources may generate more and longer hospital stays and greater use of medical services.[21] Expenditures can also increase if the subsidies provided are too small to offset the higher cost of new construction.

Whatever upward effects tax-exempt bonds have on total medical spending probably result in large part from the role of third-party payments in financing hospital care. As discussed in Chapter II, third-party payors (government assistance programs, private insurance companies, and philanthropies) altogether finance more than 90 percent of all hospital costs, and a very large proportion of these payors provide full or nearly full coverage for hospital charges.[22] This method of reimbursement assures that cost-increasing capital projects can be financed. Thus, it gives hospitals no incentive to avoid capital projects that increase average costs. In other markets, where insurance is not as prevalent, the resulting rise in prices and loss of customers would tend to limit costly capital projects. In the hospital sector, where insurance coverage is widespread, the same incentives to avoid cost-increasing developments do not occur.

POLICY OPTIONS FOR TAX-EXEMPT HOSPITAL BONDS

The Congress has many choices with respect to tax-exempt hospital bonds. Three options are explored here: maintaining

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21. This phenomenon--the tendency of increased supply to stimulate use--is sometimes called the "Roemer effect" in the health-care literature. See Milton I. Roemer, "Bed Supply and Hospital Utilization: A Natural Experiment," Hospitals, vol. 35 (November 1, 1961), pp. 36-42.

22. In calendar year 1978, third-party payers contributed about 90 percent of all hospital costs. See Robert M. Gibson, "National Health Expenditures, 1978," Health Care Financing Review, vol. 1 (Summer 1979), p. 8.

existing law, eliminating the use of tax-exempt bonds for hospital projects, and continuing to allow tax-exempt hospital bonds to be issued but requiring that they be so-called "general obligation" issues of the governmental unit issuing them.

Maintaining Current Law

Maintaining current law would preserve the existing tax subsidy for hospital construction. This subsidy, as indicated earlier, is relatively free from burdensome federal rules and restrictions. In particular, it avoids the need to obtain advance approval of the subsidy from a federal agency. Costly and time-consuming delays are thus minimized.

Maintaining current law does have certain disadvantages. Present shortcomings in health-planning activities make it hard to target the subsidy on worthwhile projects. At the same time, some hospitals cannot benefit from the subsidy because their patient mix gives them a poor credit rating. Another problem with the bonds is that they create inequities in tax treatment between similarly situated persons and give rise to relatively inefficient subsidies with little visibility and no control on actual expenditures.

The first of these problems--poor targeting--could be relieved by improving the effectiveness of the current health planning process. The second set of problems cannot be remedied so easily. This last set of problems applies equally to all tax-exempt bond subsidies, however. Thus, they would not justify singling out tax-exempt hospital bonds for special limitations unless the Congress feels that federal subsidies for hospital construction should be curtailed.

Eliminating Tax-Exempt Bonds for Hospital Projects

Eliminating the use of tax-exempt bonds for hospital projects would make tax policy more consistent with direct expenditure programs for hospital construction, which have been cut back sharply in recent years. This approach would reduce revenue losses and remove the incentive provided by tax-exempt financing for further additions to the nation's hospital capacity. In addition, it would reduce the number of opportunities for sheltering income from tax. Doing away with tax-exempt bonds for hospital construction might also lower interest costs

to state and local governments for public projects, because hospital bonds would not be adding to the supply of tax-exempt issues.[23] Eliminating tax-exempt financing could thus reduce, albeit very slightly, the cost of building schools, highways, and sewer facilities.

One problem with eliminating tax-exempt hospital bonds altogether is that few other sources of subsidized funds exist for hospitals with genuine need for new facilities. As indicated earlier, direct federal subsidies for capital projects at private hospitals are largely unavailable. The only exceptions are the Section 242 mortgage insurance program run by HUD and the more specialized programs for hospitals in areas that qualify for EDA, FmHA, and regional agency assistance. To reestablish direct expenditure subsidies for private general hospitals, HEW would have to issue regulations for implementing the subsidy program under Title XVI of the Public Health Service Act, and states without health-facilities plans would have to develop them. Neither of these actions seems imminent, although a number of states have prepared health-facilities plans during the last year. Direct expenditure subsidies could also be provided if the standards for providing them under Title XVI were modified. Modifying these rules, however, could undermine the incentives for states to limit the growth of hospital facilities through health planning--a move many health experts would oppose.[24] Thus, without further activity by HEW and the states, eliminating tax-exempt hospital bonds could remove the last major source of federal subsidies for private general hospitals.

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23. See George E. Peterson, "Tax-Exempt Financing of Housing Investment: Capital Market Impacts and Costs to the Treasury" (The Urban Institute, 1978), p. 18. Peterson has estimated that, for additional amounts of tax-exempt bonds up to about $10 billion, each $1 billion of tax-exempt bonds raises the interest rate for tax-exempt issues in general by 0.04 to 0.07 percentage points.

24. See Linda Demkovich, "Health Planning Agencies Face Threat from Deregulators," National Journal, vol. 11 (April 28, 1979) pp. 687-90; and Elizabeth Wehr, "Controversy Downplayed as Health Planning Law Comes Up for Renewal," Congressional Quarterly, vol. 37 (March 24, 1979), pp. 521-23, 538.

Limiting Tax-Exempt Hospital Bonds to General Obligation Issues

If the Congress wants to retain tax-exempt financing but improve its targeting toward hospital projects, one option would be to limit tax exemption to bonds that are general obligations of the issuing government--meaning they are backed by that government's full faith and credit.

At present, most tax-exempt hospital bonds are revenue bonds, meaning that hospital revenues are the only security for the payment of principal and interest.[25] Because state and local governments bear no financial responsibility for the issues, they have no incentive to limit them. Thus, the number of hospital issues is controlled largely by the market for tax-exempt bonds and by the ability of state health planning agencies to screen out "unnecessary" capital projects. As indicated earlier, the past effects of these agencies have not been great.[26]

If hospital bonds were general obligation issues, the number of hospitals receiving such tax-exempt funding would probably decrease. Bond markets tend to limit the amount of money a state or local agency can borrow on its own behalf. Thus, making hospital bonds general obligation issues would force them to compete with other public projects for a limited supply of government-backed, tax-exempt funding. Under these circumstances, state and local governments would probably scrutinize hospital projects more carefully and grant funding for fewer projects. This reduction, in turn, might decrease the number and size of private hospital projects. Ultimately, the effect of this approach could be to encourage the use of tax-exempt hospital financing only for projects with the greatest apparent public benefits. At the same time, it would maintain

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25. According to figures compiled from The Daily Bond Buyer by Kidder-Peabody, Inc., less than 20 percent of the tax-exempt hospital bonds issued in the last three years (1976 through 1978) were general obligation bonds.

26. See Salkever and Bice, Hospital Certificate-of-Need Controls; and Sloan and Steinwald, "Effects of Regulation on Hospital Costs and Input Use."

the availability of tax-exempt financing for private hospital projects.

Limiting tax-exempt hospital bonds to general obligation issues would have certain drawbacks. For example, competition among projects may not always mean that the most worthwhile project will receive the funds. Bond-issuing authorities are political entities, and the criteria used to select projects will not necessarily coincide with objective standards of need. In addition, jurisdictions that normally receive especially high ratings for their general obligation bonds will be given an artificial advantage in the competition for funds, even though the hospital projects being financed may not be as necessary and as financially sound as those from weaker jurisdictions.

Another problem with this option is that many states have statutory or constitutional prohibitions against using state debt-issuing authority for private-sector projects. Other states authorize their tax-exempt bond authorities to issue revenue bonds for hospital projects, but not general obligation bonds. In all these states, limiting the use of tax-exempt hospital bonds to general obligation issues would preclude hospitals from obtaining tax-exempt financing. If this option were chosen, therefore, it would probably be desirable to delay the effective date for a few years after enactment. This would give states time to reconsider existing prohibitions against providing government backing for capital projects at private hospitals and to modify these restrictions if they so desired.

U.S. GOVERNMENT PRINTING OFFICE : 1980 O - 61-467