# OVERCOMING OBSTACLES FACING THE UNINSURED: HOW THE USE OF MEDICAL SAVINGS ACCOUNTS, FLEXIBLE SPENDING ACCOUNTS AND TAX CREDIT CAN HELP

## HEARING

BEFORE THE

SUBCOMMITTEE ON TAX, FINANCE AND EXPORTS

OF THE

COMMITTEE ON SMALL BUSINESS
HOUSE OF REPRESENTATIVES

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# OVERCOMING OBSTACLES FACING THE UNINSURED: HOW THE USE OF MEDICAL SAVINGS ACCOUNTS,FLEXIBLE SPENDING ACCOUNTS AND TAX CREDITS CAN HELP

**THURSDAY, MAY 8, 2003**

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON TAX, FINANCE AND EXPORTS,
COMMITTEE ON SMALL BUSINESS,
*Washington, D.C.*

The Subcommittee met, pursuant to call, at 2:05 p.m., in Room 2360, Rayburn House Office Building, Hon. Patrick J. Toomey [chairman of the Subcommittee] presiding.

Present: Representatives Toomey, Millender-McDonald, and Majette.

Chairman TOOMEY. The hearing will come to order. Good afternoon. Thank you all for being here and welcome to this hearing today on the topic of "Overcoming Obstacles Facing the Uninsured: How the Use of Medical Savings Accounts, Flexible Spending Accounts and Tax Credits Can Help." today we are going to take a look at various proposals, all of which are aimed are decreasing the distressingly high number of Americans who currently have no health insurance. As you are probably aware, total numbers approximately 43 million Americans of whom about 60 percent of Americans without health insurance are either small business owners or employees of small business owners. Clearly here in Congress, we ought to be looking at this pressing problem and looking to find solutions which will create an environment in which these people can find not only access to health insurance, but make sure it is affordable for them.

The problem is certainly not limited to small businesses, but it does disproportionately affect small business. And part of it is a series of unfortunate features in the Tax Code that actually make it harder for individuals to obtain health insurance than it has to be. Our Tax Code systematically restricts individuals from exercising the freedom to purchase health care plans that would work best for themselves and their families if their employer doesn't happen to offer such a plan.

Employers, for instance, are able to deduct the full cost of purchasing a health care plan for their workers. However when an individual looks to either go outside of the company plan or if their company does not offer a plan, the individual simply cannot deduct the full premium that they pay unless a whole number of criteria are met, and even in those cases the individual workers bears a

cost that the employer does not bear. This is one of the many inequities in our Tax Code that makes it hard for people who do not have health insurance to obtain it and we ought to look at ways to address this problem. This inequity in the Tax Code is itself an anachronism left over from World War II policies, in other words, it frankly is an accident of history and we need to be looking for ways to find health care delivery systems that work not just those that we have always had.

One of the reasons this is so important, as the chairman is going to testify soon, knows so well is that health care costs are simply spiraling out of control. The NFIB has reported that health care costs are rising about 15 percent just this year alone for employers with fewer than 200 employees and nearly that much for those with 500 or more employees. And even before these increases for this year small businesses were already struggling to keep health care costs affordable for themselves and their employees. We need to keep in mind small businesses have a particularly difficult burden because the administrative overhead, the insurance company underwriting expenses, adverse selection problems, all of these make it harder for small businesses to obtain the health insurance that they would like to be able to provide for their workers.

Now there may not be a single simple solution to this, but there are probably a number of ideas that we can promote which will together help to alleviate this problem. I think removing the current restrictions on medical savings accounts, in flexible spending accounts and increasing tax relief focused specifically towards the purchase of health insurance will certainly be very, very helpful in all of those respects. And today we will be focusing specifically on the expanded use of MSAs and FSAs as well as increasing tax relief for health care in general.

We are very fortunate to have with us today the chairman of this Committee, Chairman Don Manzullo. And I want to first thank the chairman and recognize the enormous contribution he has made to bringing attention in this Congress and in previous congresses to the problems that face the small business employees, employers and all of the millions and millions—tens of millions of Americans whose livelihoods depend on the success of small business.

In particular, Chairman Manzullo is going to be sharing his views on his bill H.R. 1873, the Self-Employed Health Care Affordability Act of 2003, legislation that he recently introduced and that would provide for the deduction of health insurance costs for self-employed individuals when determining the self-employment tax. This, if I could add my editorial comment, Mr. Chairman, I think is an excellent bill. Clearly what this does is it eliminates an inequity in the Tax Code, a disadvantage that the self-employed currently unfairly suffer with. And I commend you for your leadership on this issue for introducing this bill. And at this point, I would recognize the gentleman from Illinois, my chairman, Mr. Manzullo for his testimony.

[Mr. Toomey's statement may be found in the appendix.]

**STATEMENT OF THE HON. DONALD MANZULLO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS, CHAIRMAN, U.S. HOUSE OF REPRESENTATIVES SMALL BUSINESS COMMITTEE**

Mr. MANZULLO. Thank you, Mr. Chairman. I appreciate the opportunity to be here. We held a hearing in the full Committee about a month ago, and Bob Hughes, who is the president of the National Association for the Self-Employed asked a rhetorical question. At that hearing, he said how would you like to lower the cost of health insurance for the self-employed immediately by 15 percent? And I said well, you know, how do you do that? And he said, well, a corporation does not pay FICA tax on the very dollars that it uses to buy health and accident insurance, but a self-employed person does.

And that means that for the money that is used to purchase health and accident insurance by an unincorporated self-employed person, that individual, that proprietor, sole proprietor pays 15.3 percent FICA tax on top of the very dollars that he is using to buy health and accident insurance. So we were—I was obviously intrigued with the idea of reducing health costs 15 percent across the board. My brother is a sole proprietor and runs a family restaurant. He is a modest man. He calls it Manzullo's Famous Restaurant. But he is proud of the fact he has 13 tables and 13 bar tools and he offers no health and accident benefits to his employees.

He is only opened on weekends, which is very interesting. And just to buy premiums or just to pay for the premiums on the health and accident insurance that he has to pay for him and his wife, it is $1,000 a month. And he has been shopping around trying to get different prices, but bottom line, if he is paying a $1,000 a month for health and accident insurance, he is paying an extra $150 more for that same policy than if he were an employee and the corporation were buying that policy and it was at the same price.

Obviously, it would be cheaper by the corporation because more people would be involved in the pool. And so here is a guy who is not incorporated, penalized because he is not incorporated and we try to come up with a plan. First idea was well, maybe there is a bill out there, a vehicle, that you simply eliminate the payment of the FICA tax as with corporations. That would have a huge dent in the Social Security trust fund. So what this bill does, it allows our nation's 16 million self-employed business owners to deduct their health insurance expenses when calculated on payroll taxes, which consists of payments to Social Security and Medicare.

It is above the line as opposed to being below the line. It is almost revenue neutral. It comes up 1 to 2 billion short. And as with other legislation that involves the Social Security trust fund, that can be compensated for by transfers from the general revenue fund to the Social Security fund. And what this essentially does is anything that we can do to make health insurance more affordable for small business people, this could be the difference between somebody buying a policy of insurance or not. This could make the difference between somebody canceling a policy of insurance or keeping it going.

And obviously, even if a relatively small percentage of the people that are uninsured now decided that they could afford insurance, this makes the overall insurance pool larger, less cost shifting and eventually brings down everybody's premium. This is a very, very simple bill. And it is the type of thing where you draw the bill and you ask yourself, you know, why did it take so long to come up with a bill that is this simple. And I think it has a lot of traction. Farmers, self-employed, independent contractors, anybody who pays 15.3 self employment payroll tax will reap considerable savings from this legislation. We drafted the legislation. Gave it to Nydia Velazquez, the ranking Democrat member of the Committee. She embraced it immediately. And our goal is to take this. And when we get towards the conference between the House and the Senate, throw that into the mix and say, you know, when you are talking about the 350 billion or 550 billion, you know, 1 to 2 billion a year to get rid of this disparity between the self-employed incorporations, it would be a pretty good investment for our Nation's small business people.

[Mr. Manzullo's statement may be found in the appendix.]

Mr. TOOMEY. Thank you, Mr. Chairman. I would like to follow up on that point because another way to look at this would be the cost of this bill compared to the total amount of revenue that the Federal Government is expected to take in annually, which, as you know, is well over $2 trillion.

Mr. MANZULLO. That is a lot of money, even if you are from Pennsylvania.

Chairman TOOMEY. Yeah. Even if you work for the Federal Government, that is a lot of money. So if I understand you correctly, the total cost per year would be a maximum of $2 billion. In the context of a budget that exceeds 2 trillion, what you are saying is this would cost the Treasury less than 1/1,000th?

Mr. MANZULLO. Whatever the percentage is, but you could also compare that to the tax cut that is before—I mean this, in effect, is a stimulus.

Chairman TOOMEY. Another question. The individuals who would benefit from this, the self-employed individuals, am I correct in understanding that the Tax Code currently acknowledges that they ought not to have to pay income tax on the health insurance premiums that they purchase for themselves? That is a deductible expense. But yet, for some reason that is a mystery to me, it does force them to pay the equivalent of the payroll tax.

Mr. MANZULLO. Depends at what point you deduct it. And here, it is—I guess the word often used is above the line as opposed to below the line on it. But it is deducted so that it works towards a situation where you are not really going to be paying tax on that. And then you have that 1 to 2 billion dollars a year that is in a revenue transfer that keeps the Social Security fund intact.

Chairman TOOMEY. In other words, if your bill is enacted, passed and signed into law, the net effect would be that a self-employed individual would be finally on a level playing field paying the same kinds of taxes as the employer and worker at a corporation.

Mr. MANZULLO. That is correct.

Chairman TOOMEY. So all you are trying to do, you are not trying to create a special advantage or a tax subsidy or any incentives per

se, you are just trying to level the playing field versus a corporate situation?

Mr. MANZULLO. That is correct.

Chairman TOOMEY. Could you just elaborate a little bit more on the issue of transferring revenues from the general fund to the Social Security trust fund. How would that work and what is the purpose of that?

Mr. MANZULLO. Let me read the answer prepared by my very competent staff, because I want to make sure I get this correct. The deduction for health insurance premiums provided under the bill means that some slightly lower amount will be paid into the Social Security trust fund. To ensure that the Social Security trust fund is not adversely impacted, the bill provides for an annual payment from general revenue, one government account to the Social Security trust fund, another government account. This is a standard provision frequently used in tax bills that affect the Social Security trust fund.

Chairman TOOMEY. So the net effect of your bill on the Social Security program, the Social Security system, the funding thereof is zero?

Mr. MANZULLO. That is correct. That is correct.

Chairman TOOMEY. I didn't have any other questions, Mr. Chairman. Did you have any closing statement you would like to make?

Mr. MANZULLO. The name of the bill, it is the Self-Employed Health Care Affordability Act of 2003, and it is H.R. 1873. And thank you for inviting me. Let me give you the names of the organizations that are behind this bill. National Association for the Self-Employed, the National Federation of Independent Businesses, American Farm Bureau Federation, National Small Business United, Small Business Legislative Council, Women Entrepreneurs Inc., Women Impact and Public Policy, Communicating for Agriculture and the Self-Employed, National Association of Women Business Owners, American Small Business Alliance and U.S. Chamber of Commerce. I think this is really exciting. I think it is something that has a lot of traction. And as I said, we will try to throw it into the mix during the conference. And this thing will be a real home run.

Chairman TOOMEY. I am happy to be a co-sponsor of the bill. Thank you very much for your testimony today and for your leadership on this bill, and at this point, I will call up the second panel.

Mr. MANZULLO. Thank you.

Chairman TOOMEY. We have a little challenge with the voting schedule. A vote was just called. My understanding is that we have a 15-minute vote followed by 10 minutes of debate, then followed by two subsequent votes, one of which will probably be 15 minutes, the other of which will be 5. So I am afraid we are going to have a significant interruption during the course of this. What I would do is introduce the second panel. Ask the first witness to testify and at that point, we will have to break, certainly no later than that and we will come back and resume the testimony.

To begin our second panel, we have Mr. Tom Miller, who is the Director of Health Policy Studies at CATO Institute. Mr. Miller has written and lectured extensively on the use of tax advantage mechanisms for health insurance. We are fortunate to have him with us

here today. We have Mr. Kim Snyder, President of Eastern Industries, Incorporated, based in the Lehigh Valley of Pennsylvania. My constituent and my friend, welcome, Mr. Snyder. Mr. Snyder is also the Chairman of the Board of Governors at the Lehigh Valley Chamber of Commerce.

Also sitting on our panel is Mr. Keith Hall. Mr. Hall is a self-employed CPA based in Houston Texas. That is a true micro business. And I am pleased to hear your testimony. And rounding out our panel we have Mr. Edwin Park, senior health policy analyst at the Center on Budget and Policy Priorities.

At this time, I would recognize Mr. Miller for five minutes.

**STATEMENT OF TOM MILLER, DIRECTOR, HEALTH POLICY STUDIES, CATO INSTITUTE**

Mr. MILLER. Good afternoon, Mr. Chairman and members of the Subcommittee, I am Tom Miller, director of Health Policy Studies at the CATO Institute. It is a pleasure to appear before you today. Removing or redesigning restrictions on the availability of medical savings accounts, flexible spending accounts and tax credits for health insurance would improve access to affordable health insurance and health care for millions of uninsured Americans. Even more progress could be achieved by providing broader parity in the tax treatment of health insurance financing for all purchasers—reducing artificial tax and regulatory barriers to market-based value maximizing choices and empowering all health care consumers to match their own needs and preferences to a wider variety of affordable options.

The relatively higher cost of small group insurance coverage for comparable benefits is one of the primary reasons why many small employers don't offer it and some of their employees don't demand it. Market-based public policy can't and shouldn't overcome all of the natural cost differentials between large and small employers that may be due to the stability, size and composition of a given employer's pool of insurable workers as well as any relative economies of scale and benefits administration.

But tax and regulatory policy should, at a minimum, avoid making those cost differentials greater than they need to be. One of the primary factors driving health care costs higher in the past has been the increased share of medical bills paid by third-party payers, such as private health insurers, employers and government health program administrators. It insulates individual consumers from the real costs of their health care decisions and treatment. The centerpiece of market-oriented health care that can reverse this trend remains medical savings accounts. Less comprehensive insurance coverage under MSA plans would mean more affordable coverage for most Americans, including a larger fraction of people with low incomes.

MSAs help control costs, improve access to health care, expand consumers' choice in control of their care and increase savings. Moreover, MSAs' improved health plan option is not just for affluent and healthy individuals, but for all Americans. However, the potential of MSAs has been hampered by eligibility limits and other design flaws mandated by HIPPA. Congress needs to allow an unlimited number of people to have MSAs and to expand Archer

MSA eligibility to include employees and businesses of all sizes as well as employees without any employer sponsored insurance.

Now, regarding flexible spending accounts, allowing unspent balances in FSAs to carry forward into the next year without being forfeited or subject to taxes would remove the most flawed incentives under their current rules, eligible workers who become more likely to participate in FSA options and to dedicate more funds to them. Enabling workers to invest their fund balances and providing full FSA portability as they change jobs also would encourage a further restructuring of private health insurance markets.

FSAs could become the primary vehicle for financing medical procedures and health services that involve relatively predictable expenses and are easily foreseeable in the future. Regarding tax credits, more than 50 years of health policy, history should remind us of the costs as well as the benefits of the special tax treatment of employer sponsored insurance. The best way to remove tax policy distortions in health insurance markets would be to eliminate tax subsidies for employment-based health insurance altogether matched by equivalent reductions in marginal income tax rates.

But the next best policy would be to offer a new Federal tax credit option, most likely amounting to 30 percent of the cost of qualified insurance coverage. This new option would not eliminate the current tax exclusion, it would provide a competitive alternative for workers to opt for in place of the tax exclusion. It would encourage a more gradual transition toward other forms of private insurance coverage. The tax credit option also would be made available to other individuals and families that currently don't qualify for the tax exclusion because they lack access to employer sponsored insurance coverage.

Now if Congress feels compelled to provide refundable tax credits to lower income Americans for reasons that tend to blur universal coverage goals with income redistribution objectives, why not simply provide equivalent income support through more targeted delivery of fungible cash vouchers and then concentrate on implementing broader health policy reforms and improving the availability of more affordable health insurance options in private markets.

In any case, new tax subsidies for health insurance purchasing should pass through directly to individual consumers rather than be used as initial sweeteners to induce employers to maintain or establish job-based coverage. Thank you.

Chairman TOOMEY. Thank you, Mr. Miller, for your testimony.

[Mr. Miller's statement may be found in the appendix.]

Chairman TOOMEY. We are now down to about 5 minutes before our vote. At this time, the Committee will recess until the end of the series of votes. And then we will resume our work immediately following the last in the series.

[Recess.]

Chairman TOOMEY. The Committee will come to order. I would like to thank the witnesses for their patience. It was quite a long delay and interruption. But as you know, we have no control over the voting schedule here, so I appreciate you bearing with us. And at this point, I would like to recognize my friend and the gentleman from the Lehigh Valley of Pennsylvania, who has provided

some great leadership on the Board of Governors of the Chamber of Commerce, if I might observe. Welcome, Mr. Snyder, and we welcome your testimony.

**STATEMENT OF KIM SNYDER, BOARD OF DIRECTORS, LEHIGH VALLEY CHAMBER OF COMMERCE, PRESIDENT OF EASTERN INDUSTRIES INCORPORATED**

Mr. SNYDER. Thank you, Congressman. As you have alluded to, my name is Kim Snyder and I am chair of the Lehigh Valley Chamber of Commerce. And I am here to testify on behalf of our 4,000 members. As you know, the Lehigh Valley Chamber of Commerce is the second largest, fastest growing Chamber of Commerce in the State of Pennsylvania. We pride ourselves on that. And we also pride ourselves on the fact of the 4,000 members, 3600 are actually small businesses. And as you can imagine, insurance is a major issue. One of the reasons why we are not only the largest and fastest growing, but have one of the highest retention rate in the Nation is because we work hard at serving our members, and we have been working hard with regards to health insurance for our members.

As I mentioned, 3600 of our members are small businesses and it is a real struggle for them. We have a team of volunteers and staff that work year end and year out to try to secure a health plan which is affordable. It is a struggle. Of those 3600, 700 find the insurance we are able to procure for them affordable. We estimate that another thousand have insurance through other means or other carriers. But what that means is that there are 1900 members of our Chamber we are estimating that do not have health care. Now it is a growing problem. There has been a lot of discussion and debate not only nationally, but on a statewide basis, as you know, with regards to how do you tackle this health care cost issue, and it is a big problem.

And I don't think there is any one big quick fix that can take place in a very short period of time. Having said that, there are a couple of instruments that are available now that would go a long way to helping small business if there were some small, in my opinion, small modifications made to them, and of course, I am talking specifically about MSAs, FSAs and some tax credits for small business.

First let me talk about MSAs. They are a great vehicle. They could be much better. The fact of life is that a lot of our members do not participate. They perceive there are barriers to entry. One is, it is not permanent, it is temporary. And they want to know that there is something there that they can count on for years to come. And we need to take this program and get it out of the pilot phase and make it permanent. Once that is done however, there are a couple of things.

First of all, what we need to do is lower the deductibles. The fact of life is that statistics show that a majority of the folks that do have MSAs never get to the point where they exceed their deductibles and therefore they see, you know, most people know that and they don't see any need to join. We would recommend that you reduce the deductibles for individuals down to $1,000 annually and for families, $2,000. Now keep in mind that those who have

tried the MSAs, over 70 percent of those that are now in the program were not insured before. And of that 70 percent are not only individual employees but families. So you are talking about spouses and children also. So obviously, there is some real value there, but because of these roadblocks, not everybody is taking advantage of them. The other thing is there is a restriction, as you know, that either the employer or the employee contribute and not both. If you remove that restriction, it would go a long way in promoting this good plan.

The flexible spending account, it needs to be flexible. As you know, you have to estimate how much to put in and if you don't spend the money by the end of the year, you quote, unquote, "lose it." people think we are gambling with their money. In essence, they are. At the very worst, what happens is that at year end what they do is go out and try to get products and services to spend the money rather than—because they don't want to lose it and that is not smart health care purchasing either. What we believe should happen is allow for rollover, so any unused portion of FSA that is still in the account can be rolled over in following years. That is also important because health care costs have gone up and we believe will continue to go up and they will need more resources to take care of those additional costs in the future. This will help offset that.

We also need to have a provision where they can take it with them. If somebody goes from one job to another, they can carry any unused balance with them as an individual.

And finally tax credits. There are people on the panel that are much more qualified than I am to talk about those particular issues as far as tax credits for small business, but I can tell you there are members saying that they follow what the national trend is and studies that have been carried on with small business folks and a vast majority of them would be much more open and much more willing and would pursue actually buying or procuring health care benefits for their employees if there was a tax credit associated with getting that health care.

So I think in the short-term, until the larger problem of the whole health care costs and issues facing us in the next couple of years is taken care of, I think these fixes taken care of right away will go a long way of not only keeping the uninsured ranks from growing, but actually shrinking them when you are talking about our small business owners.

Chairman TOOMEY. Thank you very much Mr. Snyder.

[Mr. Snyder's statement may be found in the appendix.]

Chairman TOOMEY. At this time, I would be happy to welcome and to recognize Mr. Hall for his testimony.

**STATEMENT OF KEITH HALL, NATIONAL ASSOCIATION FOR THE SELF-EMPLOYED**

Mr. HALL. Thank you, Mr. Chairman. I appreciate the opportunity to be here. Again, my name is Keith Hall. I am a CPA and a small business owner. And I am here representing the National Association for the Self-Employed, an organization that I have been a member of for over 10 years. One of the main goals of the NASE is to combine the influence of the over 250,000 self-employed and

micro business owners that they represent with the voice of those micro business owners can be heard. Now this is a voice that doesn't ask for special favors or special tax incentives. It is a voice that only asks for the same opportunity for success that is afforded to big business.

The voice of the self-employed is not always loud, but it is always big. There are currently over 18 million self-employed and micro business owners. And these people create over one-third of all the new jobs in this country. This group also employs over 12 million other workers which comprise over $309 billion of annual payroll. This is a big voice. A major issue faced by these micro businesses is the ever increasing cost of health coverage, which is what we are here to talk about. The situation for the small business is critical. According to a June 2002 survey released by the NASE, 7 out of 10 micro businesses don't provide health coverage for their employees and don't have coverage for themselves. The main reason for this decision is the cost of the coverage. Participants in the survey say the situation is getting worse because not only do they continue to see double digit increases in the premiums, but the coverages are decreasing and their options are decreasing.

I am here today on behalf of the NASE to voice its strong support for health care tax credits and also H.R. 1873, the Self-Employed Health Care Affordability Act of 2003. This is a bill that has as its sole goal providing small business with the same opportunity for success as big business has in affording quality health care coverage. As with most of us here, I wear a lot of different hats. I am a father and a husband. I run a small business. I am the treasurer of my Sunday school class. I serve on two corporate boards of directors and I am in office of my kid's high school booster club. But today, I am concerned about the cost of health coverage for my family. I pay about $600 a month for health coverage, which is a little over a 7 grand a year, which is pretty reasonable because a lot of self-employed pay as much as $13,000 a year. Now it is time for me to prepare my tax return.

Those premiums are deductible, but they are only included on the face of my tax return. They don't get deducted on the self employment tax side of my tax return. Big businesses get to deduct the health insurance premiums for their officers and employees before any tax is taken into consideration. So what does that really mean? The bottom line is before anything else is considered, my health insurance costs 15.3 percent higher than the guy next to me just because I am self-employed. Everything else may be exactly the same. He may have the same family size, the same medical history, the same health concerns, even the same weight problem that I have, but just because I am self-employed, I have to pay 15.3 percent higher. That is a little over $1,200 a year just for me and my family.

And small business, the self-employed is the only group that has to pay the extra tax on the health insurance. Imagine going to a movie and the guy in front of you pays $14 for 2 tickets for he and his wife. When you get to the window, the clerk says that will be 16 bucks just because you are self-employed. Same person, same movie, same seat, same popcorn, everything is the same, but it costs you 15 percent more. It doesn't make sense. The cost differen-

tial is not designed to influence the buying habits of the consumer like a cigarette tax or an alcohol tax. The difference is not designed to provide assistance like with the earned income credit or the child tax credit. It is just a differential that is in the Tax Code that I think has been overlooked until now.

I am certainly not a health care expert, and I am not an insurance expert, but it is my bias that affordable health care in the United States in 2003 is a tough issue. The members of this Committee, and on a larger scale the members of the House and the Senate as a whole, are asked to make tough decisions everyday. As an average American, I greatly appreciate the efforts you guys go to to make those tough decisions. I can only guess how refreshing it must be when an easy decision comes along. From where I stand H.R. 1873 is an easy decision that just happens to be wrapped up in a very tough issue.

Providing the small business guy with the same benefits big business has is the right thing to do. And it immediately will provide a 15 percent cost savings to millions of small business owners. There is no reason why my movie ticket should cost more than the guy next to me and the same goes for my health coverage. The NASE strongly supports the bill. They know that there is no silver bullet that can fix everything. The NASE also supports health tax credits which can be the beginning to addressing the bigger issue of health care affordability. We also support SAVE, the Act sponsored by Kay Granger and Albert Wynn.

And we most importantly support proactive efforts in finding solutions to this problem. I really appreciate the opportunity to be here. Thanks again for all that you guys do at the bigger level for working so hard to keep this country strong and healthy and helping people like me to afford it.

Chairman TOOMEY. Thank you, Mr. Hall, for your testimony.

[Mr. Hall's statement may be found in the appendix.]

Chairman TOOMEY. At this time I would welcome and invite the testimony of Mr. Park.

**STATEMENT OF EDWIN PARK, SENIOR HEALTH POLICY ANALYST, CENTER ON BUDGET AND POLICY PRIORITIES**

Mr. PARK. Thank you, Mr. Chairman. I would like to thank the chairman and ranking member for the opportunity to testify today. My name is Edwin Park and I am a senior health policy analyst at the Center on Budget and Policy Priorities. The Center is a nonprofit policy institute here in Washington that specializes in fiscal policy and in programs and policies affecting low and moderate income families. My testimony focuses on two tax proposals that are the subject of today's hearing, medical savings accounts, MSAs, and refundable tax credits for the purchase of health insurance in the individual market.

Both were part of the administration's fiscal year 2004 budget. While both proposals are intended to expand coverage to the uninsured, any gains in coverage are likely to be outweighed by the adverse effects these proposals impose on the traditional employer-based health insurance system. Let us first look at proposals to make the use of MSAs more widespread. MSAs can make the premiums that employers pay for traditional health insurance plans

rise substantially. People who are quite healthy can find MSAs attractive. If they do not expect to need much health care, they may prefer a high deductible policy.

In addition, unlike IRAs, there are no income limits on MSAs that prevent wealthy people from making tax deductible contributions to MSAs. Healthy people with higher incomes can find MSAs additionally attractive because of their benefit as a tax shelter. If MSAs are made widely available, then young healthy people may choose to participate in substantial numbers, but older and sicker people would want to stay in traditional health insurance plans which generally require low deductibles and copays and provide comprehensive benefits. Because the traditional insurance pool would then have high risk, premiums will increase perhaps substantially making such coverage increasingly unaffordable.

At the same time, it is unlikely that many more people would gain coverage as a result. I note that small businesses are already able to offer MSAs, yet, in general they provide traditional health insurance plans or unfortunately do not offer any coverage at all. Let us now look at individual tax credits and how they would affect the traditional employer-based health insurance system. The availability of the tax credit can lead to some employers to drop coverage for their workers and can induce many new employers not to offer coverage.

The credit is also likely to draw younger, healthier workers away from employer coverage into the individual market. This leaves older, sicker workers behind driving up the average cost of employer based insurance. In response, employers may raise employee contributions leading even more younger, healthy workers to opt out. An insurance death spiral could result in which employers can no longer afford health coverage. Because small business premiums rise faster than average, they would be especially vulnerable to these increases. Many workers with health insurance now, especially those who are older and sicker, could therefore become uninsured.

While some young and healthy people may be able to gain coverage through tax credits, many of the uninsured who are often in poor health may still remain without health insurance, even with the availability of a tax credit. That is because the individual market is generally unregulated. Insurers can vary premiums based on age and medical history, so-called medical underwriting, and can exclude people entirely. A family containing old or sick members could find itself excluded from coverage in the individual market or charge premiums that are unaffordable, even with a credit.

Alternatively, such a family could be offered a plan that is affordable but does not provide coverage for a variety of significant medical conditions. Many plans in the individual market do not offer comprehensive coverage. They may require high deductibles, impose significant cost sharing and provide minimal benefits. Even if an individual can't find a policy in the individual market, the proposed tax credit is not likely to make insurance more affordable. In order to obtain comprehensive benefits, even healthy individuals and families using the credit may have to pay 15 to 30 percent of their total income just to pay the premiums. Yet, for example, many of the uninsured workers and small businesses have low

wages and are not likely to be able to afford health insurance in the individual market.

If one wishes to address the problem of the uninsured through the Tax Code without undermining traditional employer-based health insurance, a superior alternative would be a tax credit provided to small businesses directly to help them subsidize the cost of their health insurance premiums. According to the survey by the Kaiser Family Foundation of small businesses, 89 percent of small businesses support this kind of approach. An employer credit would have the benefit of bolstering the ability of small businesses currently providing traditional health insurance to continue to do so. It could also encourage small businesses now unable to offer coverage to begin to provide health insurance benefits for the first time.

Such a credit would be most cost effective if the credit was targeted to the small businesses than most need financial assistance. These would be businesses with the fewest workers and a substantial number of low wage workers who are the ones least able to provide health insurance now. The employer credit could, therefore, produce gains in coverage without the adverse effects associated with MSAs and individual tax credits. Thank you very much. And I look forward to answering your questions.

Chairman TOOMEY. Thank you, Mr. Park, and I appreciate your testimony and the diversity of opinions that we have this afternoon.

[Mr. Park's statement may be found in the appendix.]

Chairman TOOMEY. I would like to begin the questioning with a question for Mr. Miller. It seems that Mr. Park has made an observation about—if I could paraphrase in a way the importance of relying on the traditional employer-based system, but it seems to me that, in some respects, this is the very system that contributes to some of the problems, which is to say it is one aspect of the dominance of third party payers that separates the patient from the role of the consumer. And I am wondering if you could comment on whether—some of the problems that arise as a result of a dominant reliance on third party payers.

Mr. MILLER. Well, the larger—it is almost fourth party payer when you get into the employer-sponsored system because you have both the effect of the employer first making the selection of insurance and then the insurer to the extent that insurance is comprehensive insulating the direct consumer of care from the full cost of it. I think a larger context of this is, some employers do a good job and others don't. However, to strain and struggle so much to prop up the smallest employers to pose as would-be organizers, administrators and selectors of insurance has got it exactly backwards. You are trying to prop up a pool that doesn't really exist. It is too small.

We certainly should treat small employers in an equivalent manner as we do other employers, but to create a kind of an artificial tax subsidy to pretend that the small employers are the best people to determine what the benefits are for their workers is kind of counterproductive. You are not going to have any choice of benefits in those type of small employment arrangements. It is going to be one choice at best. The bargaining power is not there. The adminis-

trative capabilities are not there. We may be replacing what used to be the AFDC, Aid to Families With Dependent Children, to a new version of ASBDW, Aid to Small Businesses With Dependent Workers.

I just don't think that has much to go in that regard. Some of the other things that he mentioned briefly—the evidence actually is that this would be a death spiral of adverse selection doesn't show up in MSAs. Aside from the MSAs that are currently in the marketplace, we had the same allegations made about the health reimbursement accounts, yet the experience would say that in the plans is the workers tend to be as old or older than the other workers. There is no indication of some segmenting relative to risk. In fact, if you look at the lifetime experiences as opposed to year-to-year experience, people get sick for a while and then they get healthy.

If you stay in an MSA for a long period of time, you would end up netting a benefit from it. People are not chronically sick on an endless basis. In addition, people who suffer from particular unique conditions would like to have the flexibility to choose the treatment and doctor that they want which is much more conducive with an MSA where you can spend your money as you wish and also have the ability of a relatively unrestricted catastrophic insurance plan.

So I think it stands on its head in terms of that analysis.

Chairman TOOMEY. Mr. Snyder, you represent 3,600 companies that are members of your organization. Two questions for you, one is of all the challenges that they face, and there are an awful lot of challenges for small businesses, especially in the current economic environment we are in, approximately how high does affordable health care rank. Is it in the top handful of issues that these folks are struggling with. Is it a topic that is on docket pretty much each and every time the Chamber board gets together. Is this a priority concern? And that is one question.

You listed several barriers that you think are obstructions that would—that if we removed them, would encourage greater use of MSAs. What do you think is the greatest single barrier.

Mr. SNYDER. Well, the first question, the answer is yes. This is a constant struggle for our small business members for two reasons. First of all, it is cost prohibitive in many instances for them to afford health care, and these are possible alternatives, but for the reasons I stated previously, they are reluctant to do that. But it goes beyond the concern of providing health care for their employees when it comes down to attracting new employees. The fact is they can't afford insurance and that is a barrier to getting qualified people to come and help their business grow and thrive. Add that on to the ever-increasing cost of health care insurance and so on, as you can imagine, it is a topic every month in the Chamber and how we can better help our people.

With regards to—I don't know if I can give you an answer as far as what the number one item is. I think it depends on the individuals we talk about as far as MSAs. I do know they also perceive it and it makes them better consumers. They perceive it as their money, therefore they work much closely with their health care providers in making sure it is the smartest thing to do. And we know that because it is their dollars, they are willing to spend

more time and efforts considering wellness issues and preventive care issues, things of that nature.

I can tell you with my company where we are not a small business, and we provide health care, at least we do today that, you know, those kinds of issues don't come into play when it comes to controlling the health care costs, and there is always a third or fourth party that is intervening and so on.

So I think there is a lot of positive effects to these MSA accounts that are of value. And I can tell you with regard to all the folks that I know that are in business, the issue is not is there an alternative, like MSAs as far as providing health care in the future or not, the issue is can we afford health care insurance anymore? And more and more of us are saying no.

Chairman TOOMEY. My time for questioning has expired. I do have some other questions. I will wait until the second round of questioning. At this time, I will recognize the gentlelady from California and ranking member.

Ms. MILLENDER-MCDONALD. Let me first apologize for my absence earlier because I had an amendment on the floor and then I had a markup and then the bell rang, and I had to run to the floor. So for all of you who have testified before my coming in, I apologize I did not hear you, but I have read some of your testimony. I want to ask all of you—you know, Mr. Miller, this is really not a laughing matter, it is really a very deep concern of the small businesses in my district. And I suppose we get to the bottom of what do we define as a small business and we go from that vantage point as to whether or not we can afford all of these MSAs and the flexible spending accounts and all of those that has been outlined here.

It is important to address, though, the current state of the health care crisis, especially for small businesses, if we, again, talk about all small businesses and we are talking minority women and others and we are talking about from the mom and pop stores to the ones that have, I suppose, 50 or more employees. And I think where we have to have some dividing lines because really when you talk about that person who is trying to stay or sustain as an entrepreneur as opposed to one who are sustained and really have a bottom line profit, if you will, we are talking about two different types of small businesses. And we look at six out of every ten uninsured Americans are in families headed by workers who are self-employed or work in a firm with less than 100 employees.

So how can this help that minority who has this type of scenario, fewer than 100 employees, and is trying to stay on board to break even in some cases or maybe have a slight bit of a profit. How would these MSAs or flex savings accounts help them?

Mr. MILLER. Well, to take them in pieces, the medical savings account allows the small employers to do what the employers can do best, first stay in business, continue to offer a good job to the employees the best they can, and provide the best value insurance choice that they can afford. It ultimately is the total value of what is produced in the enterprise and the worker who is working there. The money is not coming from some independent realm. By combining the lower cost premium of a higher deductible insurance policy we are targeting the dollars for insurance to where they can do

the most good, the greatest need which is high cost, serious medical conditions, which is what insurance at a minimum should be there to protect you against.

In addition, it allows the opportunity to better manage your own compensation dollar to be able to devote it and target to the type of health care expenses that the individual worker believes delivers the best value to them. And over time, as they manage their health care most effectively they reap the rewards from that. That is what the accumulation of funds and the MSA or the opportunity to spend it on other types of out-of-pocket health care would allow them to do. It doesn't allow the business to have more money than it was currently was earning. It doesn't allow the employee to have a higher wage than they had, but they get to find better value for that same amount of the compensation dollar.

Ms. MILLENDER-MCDONALD. How would you—and I am interested in trying to give some tax credits to small businesses. To me that is the first and foremost of helping them. When we talk about obstacles, those obstacles to me start with some type of tax credit. Now are you amenable to that before we get into the other proposals we have here today.

Mr. MILLER. I think we need to think about who is in need and what that need is based upon. Just because there is a small business I am not quite sure why they step up to the window and say feed me first. What is the small business supposed to be doing? It is running a business for a profit. Unless we wish to subsidize every small business in the country which doesn't have a positive profit picture, I am not quite sure what the theory in that regard entails. There may be workers in those companies who might need assistance, or at least be able to gain the same type of tax assistance that other workers do, but that is a different issue than saying in effect that somehow they move in front of the income subsidy line.

We have people who are disabled. We have people who are very low income who are not adequately being served in the traditional public program.

Ms. MILLENDER-MCDONALD. Let us get real. We are not talking about subsidies per se, we are talking about tax credits that will enable them to go into a type of health based or a health insurance type of policy or proposal. But we are not talking about a subsidy. We don't talk about subsidies when we talk about the higher end of the tax credit being given to business. We are talking about tax credits to afford them the opportunity to do other things with the funding they would otherwise have to pay in taxes.

Mr. MILLER. The current Tax Code says if you are a business, ordinary and necessary business expense includes health care compensation as well as wage compensation. It is deductible. That is available to you currently under the Tax Code.

Ms. MILLENDER-MCDONALD. And an additional tax credit you would not be amenable to then?

Mr. MILLER. I think we need to consider why we would be steering an additional type of tax assistance to some people and not others. What is the basis of equity there?

Ms. MILLENDER-MCDONALD. No. I am not suggesting that. It would be across the board.

Chairman TOOMEY. The gentlelady's time has expired and we will do another round. And at this time, I would like to recognize the gentlelady from Georgia.

Ms. MAJETTE. Thank you, Mr. Chairman, and good afternoon gentlemen. I, too, like the gentlewoman from California was not here for all of your testimony, but I certainly do appreciate you being here and your interest in sharing the information with us.

From what I understand, concerning the MSAs, they have been in existence since 1999, and at that—with that, there really haven't been very many set up in the grand scheme of things. And I guess my question is, given the small number of those that have been set up, what makes you, Mr. Miller, or any of you think that we have a large enough sample that this should be something that should be expanded to a larger number of people if there—or a larger number of businesses if the 750,000 MSAs that could have been set up still haven't been set up.

And does that indicate at all a lack of interest or that this particular model is not one that is really going to be cost effective in terms of providing the kind of coverage that we—I think we want to make sure that people have in the system?

And, Mr. Miller, if you could address that.

Mr. MILLER. Sure. The problem is not the numerical cap of 750,000. It is a problem of who was allowed to be eligible to set up an MSA. It was deliberately—the market was artificially limited to be, in effect, thwarted before it could grow. It was limited to employers with 50 or fewer employees as opposed to being available to all businesses.

That has been the fundamental reason why the MSA market has not grown larger; it hasn't been potentially large enough or attractive enough to major insurers to invest in that market, as well as some other rules that may be kind of complex and difficult to get under way.

They were set up in 1997, and then there are different estimates in terms of the number of MSAs. The IRS count tends more to be a low-ball count around the 60,000 mark. It is probably about 100,000 or so Archer MSAs currently.

What the MSA option potentially offers is simply a chance to kind of reconfigure the health benefits dollar. If you wish to kind of cut it up differently and decide to buy less insurance and provide more ability to handle health care on a first-party basis and save some money and be cost conscious, you have the opportunity to do so. So all we are trying to say is, let's have a fair and honest, level playing field experiment, which is to say, buyers of all types of health insurance and health care should be able to access this option along with any other one.

Mr. PARK. If I may——.

Ms. MAJETTE. Yes. I was going to ask you, Mr. Park, to give me your perspective on it.

Mr. PARK. Well, when the MSA demonstration project was originally established, part of the legislation included a GAO report that said, you know, this is—the GAO is going to examine to see if adverse selection actually is—which was the potential risk that some opponents had raised whether it would actually happen.

Unfortunately, because of the sample size, there hasn't really been an ability of GAO to finish that report. They never were able to analyze the adverse selection effects. So it is a question of whether we are willing to expand the MSA project to make it universally available without a cap to all individuals, all businesses, without being able to verify whether or not adverse selection could result. And as my testimony indicated, adverse selection is definitely a risk.

I think the other point I would like to raise is that one of the arguments in favor of MSAs is that it discourages unnecessary utilization of health services if you have a large deductible, for example, less comprehensive benefits. The RAND health insurance experiment which is sort of the largest examination of cost sharing found that cost sharing does reduce utilization. But for low- and moderate-income individuals, it discourages necessary use of health services. The value of comprehensive services is that people who are poorer, sicker, older, can get the services they need. And MSA could leave many of the poorer, older, and sicker workers out in the cold.

Ms. MAJETTE. Thank you.

Mr. MILLER. Well, that is overstating and misstating what the RAND—there is an evidence of kind of—some screening for high blood pressure, which could have been handled through other means, is about the only blip in the data which—that is a great exaggeration of some kind of unneeded care not being done by low-income people.

Most of the other speculation about adverse selection is simply that, speculation. We don't find the evidence actually going out there in the marketplace.

Ms. MAJETTE. You are saying screening for high blood pressure?

Mr. MILLER. It was a tiny fraction of the entire population. What the RAND experiment as a whole said was, for all the—the average user and most of the users in that experiment, their health outcomes were not affected in any way, but they consumed a good bit less health care. Primarily, they were economizing on outpatient care; hospitalization was about the same. There wasn't a lot of shopping around for different dollars.

This was done in about the mid–1970s, but these worries about folks suddenly having major health care needs not being met because of these higher deductible choices are not borne out in the RAND data whatsoever.

Ms. MAJETTE. My time has expired.

Chairman TOOMEY. The gentlelady's time has expired, and we will begin a second round and you are more than welcome to stay and ask another round of questions. And I will begin with a question for Mr. Hall.

As I was trying to follow your example, your personal example of your experience in obtaining health insurance as a self-employed individual, it sounds to me like you pay a total of about $1,000 in extra taxes, 15 percent of $7,000-odd roughly, more than what would be paid in taxes if you were an employee of a corporation providing the exact same set of services and receiving the exact same compensation.

Is that about right?

Mr. HALL. That is correct.

Chairman TOOMEY. And you mentioned that, you know, we use tax policy often as a way to try to influence behavior. And we have what we famously call "sin taxes" where we impose really quite substantial taxes on items that we think it is probably not such a great idea for people to consume, such as tobacco and alcohol for instance. And the result, of course, is to try to discourage people from consuming those things.

I wonder, do you think that we are having the unintended effect of discouraging people from going out and buying health insurance by imposing this artificially high or, at least I would argue, unfairly high tax on it?

Mr. HALL. Well, I certainly hope that is not the intent. I think I had mentioned earlier that I personally believe that this particular inequity in the Tax Code is an inequity that has been overlooked until now.

I think if you go backwards and talk about the sin tax, or trying to encourage consumers to respond in a particular different way than they are doing, to promote some action, then this tax would look like we are trying to encourage the self-employed not to have insurance, which again, based on the testimony here today, the conversations that you have got—have had over months, would certainly not make sense. But it is certainly a situation where the self-employed pays 15.3 percent more for the same coverage than the guy sitting right next to him does, just because he is self-employed.

Chairman TOOMEY. Thank you.

Mr. Park, do you support H.R. 1873?

Mr. PARK. I haven't had a chance to fully examine that.

Chairman TOOMEY. Okay. Fair enough.

I wanted to ask you a question about employer-based health care, and I am not seeking to, by any means, do away with employer-based health care. I think there are a lot of merits to it. But I also think there are problems. And, you know, I can't help but observe that employers don't typically provide any other form of insurance for their workers—life insurance or automobile insurance or property casualty insurance. It doesn't strike me as pure coincidence that those forms of insurance which an employer could go out and buy for their employees wouldn't get the same kind of tax treatment as health care insurance does.

My question is, do you believe there is something intrinsic to health care insurance that it ought to be provided by employers and that there isn't any other model; or do you think there is a better model out there?

Mr. PARK. I think the value of employer-based coverage is the pooling mechanism. I think that selection issues are certainly a phenomenon that occur when insurers look at a health insurance provision and the ability to pool together both—primarily healthy risks, low risks with older and sicker workers who may be higher risks allow the provision of health insurance at an affordable rate.

I think that if you move in the system where people are individuals out on their own, then you have a medical underwriting situation where an individual's risk is assessed, where an older and sicker worker with certain—with a very long list of medical serv-

ices in their experience history will be unable to access coverage in the individual market because it is generally unregulated.

So I think that's the value of employer-based coverage. It serves as a pooling mechanism for health insurance.

Chairman TOOMEY. So you—and the purpose, in your—if I understand you correctly, of the value of having a pooling mechanism is to avoid adverse selection.

Mr. PARK. Yes.

Chairman TOOMEY. Mr. Miller, you don't believe that adverse selection is really a problem with individually-purchased insurance; is that correct?

Mr. MILLER. No. The actual better research in the field indicates there is less pooling that goes on in the employer group market than is commonly believed. There is actually some separation like with—older workers have wage offsets, so in effect there are some implicit take-backs of what is supposed to be this great pooling of health care costs.

And in the individual market it is much more erratic. There is no kind of clear sign that, in effect, the highest risk is paying the highest cost. In fact, the problem with the individual market is, the administrative loads are so high that that kind of makes it a bad value for a lot of people until they can search out a better number. What we need is a more effective, deeper pool of parties in the individual market.

In addition, you can protect against what are your worst fears by simply adequately financing high-risk pools, which deal with a tiny fraction of the population which might be subject to high health care costs. That is something where a State or another body needs to step up to the plate and say, we recognize that these folks can't afford their health care; it is way beyond the bounds of private insurance prices for them to afford.

But that involves a small section of the market, while we should allow the rest of the market to do what it does.

Chairman TOOMEY. So in a way you are saying, we shouldn't design a system around the exception, but rather let the system work for the vast majority and then find a solution——.

Mr. MILLER. Correct.

Chairman TOOMEY.—that works for the folks that would be an exception?

I will yield the time to the gentlelady from California.

Ms. MILLENDER-MCDONALD. Mr. Miller, what would be that solution for those who are unable to be in that larger pool of businesses that would then buy into the proposals that we are outlining here today?

Mr. MILLER. Well, I am not suggesting any kind of one single pool of businesses. I don't want to kind of steer you wrong in that regard. Each business, or the worker, should decide what their options are.

The general concept of the high-risk pool tends to operate at the State level. Some States do it well; other States don't. It usually comes down to how generous they are with the funding for this.

I would point to the State of Illinois as doing a particularly good job in terms of running a high-risk pool. They, in effect, find if an individual has been denied by several private insurers, or at least

priced beyond a certain level; sometimes it is set at 150 percent of the standard rates for someone in their particular category, or 200 percent. Then, in effect, the cost of their comparable insurance coverage, run through the high-risk pool—usually through, in effect, the subcontracted private insurer—is subsidized by the State.

A lot of States probably make the mistake of imposing premium taxes on the insurers in the State, and they just recollectivize the surcharge as it is. The better way is to do it through State general revenues. But the political impulse is always to try to hide the cost, and they even kind of put it through regulatory cross-subsidies rather than simply acknowledging the fact that something ought to be paid for, it is the right thing to do.

Ms. MILLENDER-MCDONALD. Given that the MSA is a relatively new concept and the GAO report has not been completed, why are we rushing to do this?

Mr. MILLER. There are two different things going on here. The high-risk pools have been around for a long time. They have actually been growing. I think we are at about 30 States right now with high-risk pools. And if you recall, the trade adjustment assistance provisions actually provided some additional Federal seed money both for more States to set up high-risk pools, as well as to subsidize the operating costs in future years of the current ones. So I think that is something that is growing, and there is more support for the high-risk pool approach.

With regard to MSAs, again Congress set up a very bad—what is said to be an experimental demonstration project, which had a lot of flaws in it. You didn't run the—the experiment wasn't run, so in effect what was kind of a "the dog chewed up my homework" GAO response to that was simply because there weren't very many folks in it.

But there is nothing to be afraid of in allowing people to make their best value—maximizing choices in a more open environment. We shouldn't be petrified at the idea that people of all walks of life should be able to go out and spend their health care dollars for what they think works best for them.

Ms. MILLENDER-MCDONALD. Mr. Hall, how large is your business?

Mr. HALL. I have three employees and myself.

Ms. MILLENDER-MCDONALD. Okay. And so this would work well for you with three employees and yourself, these proposals that are before you today?

Mr. HALL. Yes, I believe they would.

Ms. MILLENDER-MCDONALD. Not going into your bottom-line net—your net worth, or your bottom-line profit—I will skip over that for the moment—but would you agree that expansion of MSA programs would generally benefit those who are healthy, as opposed to—and are in the higher income tax bracket?

Mr. HALL. I am not sure how to address that. I think Mr. Miller's comment on seed money, providing small business on a—first point, back to my testimony—equal footing with big business so that whether it is MSAs, it is tax credits, or it is moving the deductibility of health insurance premiums off the face of their tax return over to schedule C for self-employment tax, I think, is the critical part for small businesses like me.

MSAs, in my experience, can be relatively complicated. I think the requirements of a specific type of health insurance policy, the high deductible, the fact that there has to be a third-party administrator involved are hurdles for small business people like me.

I think Mr. Snyder had mentioned a couple of concepts of changing those deductibles required on the policies, changing things that I think would be very beneficial to people like me. My bias, my personal bias, is that it is not as attractive to the higher income people because I don't think they typically have as much of a concern for the $1,000 of extra costs that I have, that could be saved under H.R. 73 just because the dollars are different. I am not sure that is necessarily reasonable.

Maybe that's not the way that it should be approached, but I think the higher volume of money that you have, whether that is defined as earnings or cash in the bank, some of those decisions become easier. I think that is a hurdle that the self-employed, the microbusiness may have to face, that some of the larger employers, the more wealthy individuals, may lose contact with because the volume of dollars just gets bigger and it is easier to make some of those decisions.

I think there is a chance, a point-blank answer to your question, that those factors can help businesses like me. The thing I am here today to talk about personally again is moving my health insurance premiums that I do pay to the right place on my personal tax return. That seems to be the easiest approach to save me 15 percent.

Ms. MILLENDER-MCDONALD. Mr. Chairman, I am going to have to ask Mr. Park this question. I am trying to get some of that time I am recouping from the time I was not here. I just want to ask him, are there any reforms other than the refundable tax credit that will help individuals purchase health insurance when their employer does not offer coverage?

Mr. PARK. I think that, besides the credit to employers, one could also talk about public program expansions. I think that a number of small businesses, the ones who are least able to provide health insurance, are those with a disproportionate percentage of low-wage workers. The Kaiser Family Foundation, looking at small businesses they, were unable to offer coverage. Those that had an average wage of less than 2,200 per month were—less than half of those small businesses were able to offer health insurance. So these workers are in the range of 100–135 percent of poverty, where they could be able to access public programs, which is not only group coverage, but generally is affordable and provides comprehensive benefits.

Now, certainly right now, with the State budget crisis, there is a need to shore up what is currently existing for public programs through fiscal relief to States to help them maintain their current programs. But over time the State budgets recover. Being able to help them expand coverage to working parents, who are disproportionately in a lot of these small businesses, would be very helpful.

Ms. MILLENDER-MCDONALD. Thank you.

Thank you, Mr. Chairman.

Chairman TOOMEY. The gentlelady from Georgia.

Ms. MAJETTE. Thank you, Mr. Chairman. I have lots of questions. I guess the—from your perspective, Mr. Snyder, in terms of

the members of the Chamber of Commerce in your area, do they think or do you think that this is the right approach to take, the adoption of the MSAs, and that that will really help to resolve this issue of the cost of the insurance and making sure employees buy coverage and how that is going to play out in the marketplace overall?

Mr. SNYDER. The answer is, it is one of the things that can be of great help. In my testimony, I pointed out that we have over 4,000 members, 3,600 for small business, and we classify it as 50 employees or less. And one of the roadblocks for them participating—and when you talk about pooling, we work hard at the Chamber to pool our members for insurance, and while that lowers the cost that you can buy—as far as them individually, it lowers the cost—it still doesn't make it affordable in pooling in that situation.

The roadblocks are, you know, that people are uncomfortable with it being temporary. That is one reason why they haven't joined in the past. I mean, it is a very emotional issue. So the last thing you want to do is say let's go over the emotion of giving you this program, and then face the potential of a year or two down the road pulling it away again. So people have been reluctant to do it because of that reason.

The other is the relatively high deductibles. It has been pointed out that the small business person usually is—the employees are on the lower income end, and a vast majority of them have figured out, well, what is the sense of me belonging, because if I look at my cost, you know, there will be very few years where I actually hit that deductible and be covered.

I think they see it as a viable alternative to a much bigger problem that needs to be addressed now and in the future. I think they will use it more if they—if we do make it a permanent program, if we lower the deductible, if we do make a couple of changes that I have had in my testimony, I think you will find a lot more interest in that. And I don't agree, as somebody who is out there trying to get it done, that other businesses will see this as an alternative to dump—those businesses that are providing health care insurance, to dump that insurance for a less costly alternative.

Ms. MAJETTE. And what would—from your frame of reference, what would be a reasonable deductible or one that, for the most part, your members would feel as though they could accommodate and would make sense for them to have?

Mr. SNYDER. $1,000 for an individual, 2000 for a family.

Ms. MAJETTE. Per year?

Mr. SNYDER. Yes, ma'am.

Ms. MAJETTE. And that thousand deductible would have to be paid before there was any—would there be a copayment after that, once that $1,000 deductible had been met?

Mr. SNYDER. We don't get that detailed, or at least I don't—can't answer that question. I mean, the big hurdle was the deductible and how high they are. And so the incentive, or the feedback, was to go with $1,000, as I said, for the individual and 2000 for the family.

Ms. MAJETTE. And, Mr. Miller, I see you frowning.

Mr. MILLER. Well, we have just got another dog that is barking, and it isn't being heard on this issue, which is health reimbursement accounts.

In effect, we are running a different experiment that is beginning to grow, primarily starting in the self-insured, larger-employer market, but it is going to move down to the small employers fairly rapidly. That is, from last year, if you recall last year's tax ruling which, in effect, said you could get kind of like an MSA, except it had to be employer money, through a health reimbursement account.

What employers increased—they were already beginning in a post-managed-care world, trying to figure out how to make insurance affordable without the type of controls that their workers didn't want. So what they have gone to is increased cost sharing, other ways to, in effect, hollow out or carve out that front end of coverage.

What they are combining that with are what are called these "health reimbursement accounts," which are tax advantaged, in which the employer says, we will fund some up-front benefits for you to deal with things like preventive care, some things that you want to use up front, and then there is a deductible after that generally. It's usually 500, $1,000, probably about at most $2,000, and that is not most of them. And we are seeing more and more employers going to this as a way to get around what are the barriers to having straightforward MSAs.

And the general experience with these accounts is, the utilization is down, the workers are happy, the budgets are under better control, and more and more employers are going on to them. The flaw in this is that the money is exclusively the employer's contribution because of the way the Tax Code works.

It is not vested in the employee; if you leave the job, unless you have the very benevolent employer we haven't found out there thus far, you don't get to take it with you; so you don't have that kind of long-term buildup of equity that you get in an MSA. But, in effect, the market is trying to do the best it can with the tools it has.

Ms. MAJETTE. Mr. Park, did you want to jump in on this?

Mr. PARK. Well, I think the issue with health reimbursement accounts is that most of the large employers looking at these accounts are looking to cut costs. So that means that the coverage that they are going to provide, the sort of high deductible policy, similar to an MSA—but as Mr. Miller said, without the tax advantages—and the amount of money that the employer contributes to that account on behalf of the employee for use as part of this arrangement is generally going to be less than the value of the premium for more comprehensive, traditional coverage.

So for workers who have significant health care needs, who may not be able to afford that, especially those who are lower income and do not have the resources to meet that differential between the out-of-pocket costs that would be covered by comprehensive coverage and the lesser amount that may be in their spending account, plus the high deductible and other less comprehensive benefits of getting through high deductible policies.

Ms. MAJETTE. Thank you.

Chairman TOOMEY. Well, thank you all very much.

We will let Mr. Park, who has provided an articulate dissenting opinion for the most part today, and I thank him for his testimony, as well as everybody. And I would also like to thank you all for your patience during the long interruption. I think this was a very useful exchange and I appreciate the input from each and every one of you.

And the hearing is adjourned.

[Whereupon, at 11:45 a.m., the subcommittee was adjourned.]

Chairman Toomey

**Subcommittee on Tax, Finance, & Exports**
**Opening Statement on Overcoming Obstacles Facing the Uninsured: How the Use of Medical Savings Accounts, Flexible Spending Accounts, and Tax Credits Can Help**
**May 8, 2003**

## INTRODUCTION

- Good afternoon, thank you all for coming.

- Today, we are going to take a look at various proposals aimed at decreasing the distressingly high number of uninsured Americans, which currently stands at approximately 43 million.

- As you may be aware, about 60 percent of those Americans without health insurance are either small business owners, or employees of small business owners.

- Clearly, we in Congress must look at this pressing problem and find solutions that will create an environment so those that need health insurance can not only find the coverage they need, but also afford it.

- While this problem is not limited to small businesses, it disproportionately affects them.

- Unfortunately, our tax code makes it harder for people to obtain health insurance that it has to be.

- The code systematically restricts individual freedom and Americans are penalized when they look to make informed choices about their health options.

- For example, employer contributions to a traditional employer sponsored health care plan may be deducted as a business expense and they are not counted for the employers' share of employment taxes.

- However, when an individual looks to go outside the company plan, or if their company does not offer a plan, they cannot deduct their premiums unless they itemize their deductions *and* their premiums plus other unreimbursed medical expenses exceed 7.5 percent of adjusted gross income.

- This is just one of the many inequities in our tax code dealing with health insurance.

- Employers do not provide car insurance for their employees, nor do they provide home insurance, or numerous other insurance policies that most Americans need.

- Why then, are they looked upon as the almost exclusive provider of health insurance?

- The answer lies, in part, to actions taken by the Federal government aimed at controlling wages during World War II.

- In other words, an accident of history.

- We need to be working toward a health care delivery method that works best, not just what we've always done.

- A simple look at the current health care landscape shows that the system is not working.

Health care costs are spiraling out of control

- According to the National Federation of Independent Businesses, health care costs are rising about 15 percent this year for employers with fewer than 200 employees versus 13.5 percent for those that have 500 or more.

- Even before these increases, small businesses were already struggling to keep health care affordable for their employees.

- Small businesses' administrative overhead, insurance company underwriting expenses, adverse selection, and state regulatory burdens are but a few of the prime reasons small firms are likely to offer less generous benefits, if at all.

The need for new ideas

- Unfortunately, there is no magic bullet to solve all of these problems.

- We must take a multi-faceted approach to fixing them.

- I believe that removing current restrictions on and expanding the use of Medical Savings Accounts (MSAs), Flexible Spending Accounts (FSAs), and increased tax relief focused specifically toward the purchase of health insurance can help alleviate many of these problems.

Focus of today's hearing

- Today, we'll be focusing on the expanded use of MSAs and FSAs and increasing tax relief for health care.

- Throughout this hearing, there are going to be many good ideas presented about how to fix the administration of health care in America, and I look forward to today's testimony.

**Witnesses**

- Today we are lucky to have with us Congressman Donald Manzullo, Chairman of the House Small Business Committee.

- Chairman Manzullo will be testifying on H.R. 1873, the "Self-Employed Health Care Affordability Act of 2003," legislation he recently introduced that would provide for the deduction of health insurance costs for self-employed individuals when determining the self-employment tax.

- This is an excellent bill, Mr. Chairman, and as a cosponsor of this legislation, I look forward to working with you to see its passage through the House.

- That said, I would also like to thank you for your leadership on not only this issue, but for your tenacity in fighting for the interests of small businesses.

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- To start our SECOND PANEL, we have Mr. Tom Miller, Director of Health Policy Studies at the CATO Institute.

- Mr. Miller has written and lectured extensively on the use of tax-advantaged mechanisms for health insurance, and we are lucky to have him here with us today.

- We also have with us Mr. Kim Snyder, President of Eastern Industries, Inc. based in the Lehigh Valley of Pennsylvania. Mr. Snyder is also the Chairman of the Board of Governors of the Lehigh Valley Chamber of Commerce. Mr. Snyder, welcome.

- Also sitting on our panel is Mr. Keith Hall. Mr. Hall is a self-employed Certified Public Accountant based in Houston Texas. As a true micro-business, I am pleased to hear your testimony.

- Rounding out our panel is Mr. Edwin Park, Senior Health Policy Analyst at the Center on Budget and Policy Priorities

# Congress of the United States

House of Representatives
108th Congress
Committee on Small Business
2361 Rayburn House Office Building
Washington, DC 20515–6315

**Testimony of the Honorable Donald A. Manzullo**
**Chairman of the Small Business Committee**
**U.S. House of Representatives**

**Hearing on Overcoming Obstacles Facing the Uninsured:**
**How the Use of Medical Savings Accounts,**
**Flexible Spending Accounts and Tax Credits Can Help**

**Before the Subcommittee on Tax, Finance and Exports**
**House Committee on Small Business**

May 8, 2003

Good afternoon. I appreciate the time you have given me to address the Subcommittee today. It's especially a privilege to appear before this Subcommittee which I used to chair before assuming the chairmanship of the Full Committee.

The cost of health insurance has become a crisis for America's small businesses and their employees, especially the self-employed. Of the 41 million uninsured Americans, 60 percent work for small employers who can't afford to purchase health insurance for themselves or their employees.

Reducing the surging cost of health care for small businesses has been one of our top priorities here at the Small Business Committee during the past eight years. It

continues to be a priority as evidenced, in part, by this hearing today.

Last month, we took an important step toward reducing the cost of health care for the self-employed. Together with the Committee's Ranking Member, Nydia Velázquez, I introduced H.R. 1873, the Self-Employed Health Care Affordability Act of 2003. This bill would allow our nation's 16 million self-employed business owners to deduct their health insurance expenses when calculating their payroll taxes, which consists of payments to Social Security and Medicare.

For the first time this year, the self-employed can deduct 100 percent of their health care expenses when calculating their individual income taxes, but these insurance premiums continue to be non-deductible for the self-employed in calculating payroll taxes.

Self-employed business owners pay a 15.3 percent payroll tax on top of their individual income tax. Allowing them to deduct their health insurance premiums would effectively reduce their health insurance costs by over 15 percent. Our farmers, independent contractors-- anyone who pays the 15.3 percent self-employment payroll tax—will reap considerable savings from this legislation.

Not only would the bill make health care more affordable for millions of Americans, it would make our tax policy more equitable for the self-employed. Other employers currently receive a full deduction for the cost of health insurance premiums in calculating payroll taxes. It is appropriate to extend the same deduction to self-employed business owners. We should not be treating our large corporations more favorably than our small businesses.

This legislation would also help our sluggish economy recover more quickly. As President Bush has repeatedly stated, America's small businesses -- which create 75 percent of all new jobs each year -- will play a principal role in our nation's economic recovery. This legislation will strengthen our self-employed business owners -- who make up two-thirds of all small businesses in America -- and therefore will help brighten our lackluster economy.

As the President's Growth Package moves to the House Floor, and through the Senate, I am hopeful that the deductibility of health insurance for self-employed business owners can be added to that package at an appropriate juncture. I would ask the Members of the Subcommittee to join with me in cosponsoring H.R. 1873, the Self-Employed Health Care Affordability Act of 2003.

Thank you for your time.

**Testimony of**

**Tom Miller**

Director of Health Policy Studies

**Cato Institute**

Before the

**House Small Business Subcommittee on Tax, Finance, and Exports**

on

# Overcoming Obstacles Facing the Uninsured:

## How the Use of Medical Savings Accounts, Flexible Spending Accounts, and Tax Credits Can Help

**May 8, 2003**

Good morning, Mr. Chairman and Members of the Subcommittee. My name is Tom Miller. I am director of health policy studies at the Cato Institute. It is a pleasure to appear before you today to examine how potential changes to tax-advantaged mechanisms for financing health care spending can address problems faced by the uninsured.

Medical savings accounts (MSAs), flexible spending accounts (FSAs), and tax credits represent three types of tax-advantaged vehicles that could play a larger role in improving access to affordable health insurance and health care for millions of uninsured Americans. Removing or redesigning restrictions on the availability of each one of them would help reduce the number of uninsured individuals and families. Even more progress could be achieved by providing broader parity in the tax treatment of health insurance financing for all purchasers; reducing artificial tax and regulatory barriers to market-based, value-maximizing choices; and empowering all health care consumers to match their own needs and preferences to a wider variety of affordable options.

Before focusing more specifically on the three tax-advantaged vehicle options noted above, I first would like to frame the overall issue of health insurance availability and affordability within the context of the small-employer market and then the health care system as a whole.

During the recent period of annual double-digit percentage increases in the health insurance premiums, the cost issue has driven everything else within our health system,

Health insurance premium expenses have been particularly difficult for the many smaller employers that teeter on the edge of decisions whether to drop current coverage, reduce its scope and scale, or offer some sort of coverage for the very first time.

Small employers – those with fewer than 50 workers – employ almost one-third of the private sector workforce. The smaller the employer, the less likely it will be to sponsor health insurance coverage – particularly at the threshold levels of below 50 workers, and below 10 workers.

The relatively higher cost of small group insurance coverage for comparable benefits is one of the primary reasons why many small employers don't offer it and/or some of their employees don't demand it. It's generally more expensive to sell and administer insurance for small employers. About 20 to 25 percent of small employers' group insurance premiums go toward expenses other than health benefits – compared to about 10 percent for large employers. However, the administrative cost differential for small employers has been reduced over the last decade or two – it used to be closer to 40 percent of group insurance premiums, but growth in managed care and improvements in information technology narrowed some of that gap.[1] Even though basic demographic and self-reported health characteristics of individuals insured through the average small employer and average large employer do not vary significantly, it also remains harder for an insurer to predict the health status and the accompanying health costs of any particular small group. Hence, various degrees of medical underwriting are used for small groups because the law of large numbers does not kick in for actuarial predictions of future costs until a group approaches about 500 covered lives – although limited versions of experience rating begin to replace medical underwriting well below that level.[2]

Although some states do not allow private insurers to adjust premiums for the health characteristics of employee enrollees, GAO found that small employers in those states had average premiums about 6 percent higher, compared with other states, when adjusted for geographic differences in the cost of physician services. Yet those states

prohibiting insurers from setting premiums based on health status did not gain anything in terms of covering more high-risk employees. Those states did not have a higher proportion of high-risk individuals insured through small employers than states with more flexible restrictions.[3]

Lower-income workers in small firms bear the brunt of this and other forms of excessive state health insurance regulation. Their employers generally are unable to self-insure and thereby gain ERISA protection from costly state benefit mandates, restrictions on rating and underwriting, and other regulatory burdens.

Market-based public policy cannot, and should not, overcome all of the natural cost differentials between large and small employers that may be due to the stability, size, and composition of a given employer's pool of insurable workers, as well as any relative economies of scale in benefits administration. But tax and regulatory policy should, at a minimum, avoid making those cost differentials greater than they need to be.

We should also consider whether improving health outcomes and health status for lower-income individuals, rather than just reducing the total number of uninsured Americans, should be the primary goal of health care system reform. Increasing health insurance coverage levels per se remains at best an imprecise tool of limited effectiveness in achieving that objective. Hence, I have suggested elsewhere that it may well be more efficient, on balance, to improve the overall affordability of insurance coverage by encouraging it to be less comprehensive, while selectively targeting expansion of safety net care, than to subsidize expansion of conventional health insurance coverage.[4]

Making the market-based cost of care more transparent to all parties involved in health spending decisions would encourage its more efficient consumption and delivery.

Reducing the long-term rate of growth in the cost of health care remains more important than (and, beyond a certain point, operates at cross-purposes to) expanding the scope and scale of subsidized health insurance coverage. Past levels of health insurance subsidies have increased medical costs and the demand for health insurance, creating net welfare losses estimated at 20 percent to 30 percent of total insurance spending.[5] The consequences of failing to reduce, let alone further increasing, the effects of comprehensive third-party insurance in raising costs and limiting access to health care would do more overall harm than any modest disincentives to obtain insurance protection that may be caused by direct provision of more charity care. When rising health care expenditures outpace wage increases, their strongest effect is to reduce health insurance coverage for low-income workers. Hence, at the margin, increasing incentives to purchase less-comprehensive health insurance and filling in urgent gaps in direct delivery of health care through safety net mechanisms may produce more affordable and accessible health care.

If the rate of cost growth dips lower, other complaints about access, quality, and equity become much more manageable.

**MSAs**

One of the primary factors driving health care costs higher in the past has been the increased share of medical bills paid by third-party payers such as private health insurers, employers, and government health program administrators. Whereas out-of-pocket payments by individual consumers accounted for about 50 percent of total health care

spending in 1960, the share of third-party payments (by private health insurers, employers, and government agencies) for health care has grown to over 80 percent. Third-party payment of health bills insulates individual consumers from the real cost of their health care decisions and treatment. Consumers have less reason to avoid unnecessary care, question costs, or shop around for the best treatment available at a reasonable price, but they have every incentive to demand more services. Excessive third-party coverage with low deductibles also increases administrative costs, because every small bill must be submitted for review and checked for accuracy.

The centerpiece of market-oriented health care that can reverse this trend remains MSAs. They combine two elements—a savings account controlled by the insured individual to be used to pay for routine health care expenses and a high-deductible (catastrophic) insurance policy to cover more substantial health care needs.
The savings account is controlled by the insured person and used to pay routine health care expenses. The accompanying catastrophic insurance policy covers more substantial health care costs. Because the cost of such a policy is usually significantly less than the cost of a low-deductible policy, the money saved may be used to increase contributions by an individual (or his employer) to an MSA administered by a designated trustee or custodian. Unspent MSA funds, including any interest or investment earnings, accumulate from year to year, providing money to cover possible medical expenses in the future. This feature also expands the time horizons of MSA consumers to look beyond a single year at a time of insurance coverage in order to maximize the value of their health care dollars.

The evidence is overwhelming that increased cost sharing reduces health insurance premiums substantially. For example, Jason Lee and Laura Tollen noted in a June 2002 article in Health Affairs that increasing cost sharing from a plan with $15 copays and no deductible to one with 20 percent coinsurance and a $250 deductible reduces premiums by about 22 percent; and a combination of 30 percent coinsurance and a $ 1000 deductible would reduce premiums by 44 percent.[6]

Because MSA plans are linked to high-deductible insurance that covers health claims that are more catastrophic in nature, they make the cost of insurance coverage more affordable for most Americans. Less-comprehensive coverage will mean lower premiums for a larger fraction of people with low incomes. The majority of standardized insurance policies currently available are generous and expensive – making them unaffordable to low-income people. On the other hand, catastrophic insurance for very large, less-predictable health care expenses forces consumers to bear the full marginal costs of health care up to the point where their use of health care exceeds the deductible.

Because MSAs funnel a much smaller share of health care spending through third-party insurance, they provide workers strong market incentives to control the costs of their health care. Account holders are effectively spending their own money for routine health items. That, in turn, stimulates real cost competition among and price disclosure by doctors and hospitals.

Offering less comprehensive insurance plans with greater enrollee financial responsibility is designed to encourage enrollees to be smarter consumers of health care services, limit demand for less beneficial "discretionary" care, seek out higher-value options, and save money for more critical medical needs in the future. Under many third-

party health benefit arrangements, consumers have little incentive or ability to become more knowledgeable about health care. MSAs stimulate consumer demand for information about the quality and price of health care.

A number of studies have illustrated that MSAs help control costs, improve access to health care, expand consumers' choice in and control of health care, and increase savings. Moreover, MSAs improve health plan options not just for affluent and health individuals, but for all Americans.

In April 2000, RAND Corporation researchers examined the effects of making MSA options available to small businesses. RAND rejected the assumption that MSAs appeal most to the wealthiest and healthiest workers. It found that HMOs would remain more attractive to higher-income workers, primarily for tax reasons, and exceptionally good health risks would be more likely to decline any insurance at all than to select the MSA option.[7]

A 1996 study by National Bureau of Economic Research analysts (including current FDA commissioner Mark McClellan) concluded that most workers would end up retaining a substantial portion of the contributions they made to MSAs by the time they retired. Approximately 80 percent of employees would have retained over 50 percent of their MSA contributions by the time of retirement, and only 5 percent of workers would have saved less than 20 percent of their contributions. Although workers with high health care expenses in one year tend to have lower but still higher than average expenses in the next few years, the concentration of annual expenditures declines continuously as more and more years of expenditures are cumulated. High expenditure levels typically do not last for many years.[8]

Another 1996 study of Ohio-based firms that offered MSAs that did not qualify for tax advantages under the Health Insurance Portability and Accountability Act (HIPAA) determined that the employer's total cost for family coverage under those MSA plans averaged 23 percent less than traditional family coverage, yet the average employee with family coverage also would be $ 1355 better off under the worst-case (maximum out-of-pocket liability) scenario.[9]

So, if MSAs are so great, why don't we see more of them in the marketplace?

The 1996 Health Insurance Affordability and Accountability Act authorized up to 750,000 "tax-qualified" MSAs over a four-year period (later extended to December 31, 2003). Unlike previous MSAs, those so-called Archer MSAs featured tax-deductible treatment of MSA deposits and tax-exempt treatment of investment earnings accumulated with the MSAs. However, the potential of Archer MSAs has been hampered by eligibility limits and other design flaws mandated by HIPAA.

Congress still needs to permanently authorize federally qualified MSAs; lift the enrollment cap and allow an unlimited number of people to have MSAs; expand MSA eligibility to include employees in businesses of all sizes, as well as employees without employer-sponsored insurance (ESI); allow MSA plans to offer a much wider range of deductibles; allow MSA holders to fund fully their MSAs each year, up to 100 percent of the insurance policy deductible; allow employers and employees to combine their contributions to MSAs at any time within a given year; and either preempt first-dollar state-mandated benefits or provide the flexibility for MSA plans to adjust to comply with those conflicting mandates.

Even under the current burden of the handicaps imposed by HIPAA rules, MSAs have become particularly attractive to the insured. Last October, the Internal Revenue Service reported that 73 percent of taxpayers filing MSA tax returns for the taxable year 2001 previously lacked any health plan coverage at some time within the six-month period before their high-deductible/MSA coverage began. Archer MSA eligibility is not only prohibited for individuals who work for companies with more than 50 employees; it also does not extend to workers in companies, of *any size*, that do not offer MSAs as a benefits option or even in companies that do not offer any kind of employer-sponsored health insurance at all!

Expanding MSA eligibility to all health insurance purchasers and permanently authorizing tax-advantaged treatment for Archer MSA coverage would deepen the potential market for MSA plan vendors and encourage larger insurers to invest the necessary resources to develop and market such products. It also would increase the level of consumer knowledge of the uninsured, or "cash market," prices for more discretionary health care services and products. Finally, it would help facilitate the potential convergence of MSA options with other tax-advantaged vehicles for health care spending, such as health reimbursement accounts (HRAs) and FSAs.

**FSAs**

FSAs have a longer history than MSAs. These tax-advantaged health spending vehicles were first approved by Congress in 1978. FSAs allow an employee to authorize a pre-tax salary reduction amount, generally in the first month of a given calendar year, that will be transferred into an account to be used to pay directly for health care expenses,

as defined quite broadly by section 213(d) of the Internal Revenue Code. FSA contributions are exempt from both income and payroll taxes.

Access to FSAs and greater use of them are limited by several rules. Eligible employees must work for a company that decides to offer an FSA benefit option; they cannot set up a personal FSA on their own. They also must lock in their annual contribution amount early in the year and cannot adjust it later. Any unspent balances in a worker's FSA at the end of the calendar year are subject to "use it or lose it" penalties. Forfeited funds revert back to their employer.

According to James Cardon and Michael Showalter of Brigham Young University, major U.S. firms are the most likely employers to offer FSAs.[10]. Actual participation rates by employees remain relatively low. Decisions regarding whether to participate, as well as how much to contribute, tend to be quite conservative, and they are primarily based on employees' foreknowledge of their likely health expenditures in a given year. Participants tend to spend their FSA amounts relatively early in the year (Cardon and Showalter note that January 1 appears to be busiest day of the year for FSA charges and that nearly 11 percent of FSA expenditures for the year are incurred in the first week of January). They then run a negative account balance for most of the year until their periodic contributions to the FSA catch up.[11] This incentive to use FSAs as interest-free loans from benefits administrators also places a sponsoring employer at risk for the portion of any upfront FSA expense reimbursements that would not be fully repaid if an employee left the firm before the end of the year.

Although the median exhaustion date for the FSAs in the Cardon/Showalter sample was early October, some portion of all FSA holders are likely to miscalculate

their ability to hit their health spending targets. As the end of year nears for them, the use it or lose it penalties provide strong incentives to spend remaining funds on less valuable health services (triggering the so-called "designer sunglasses in December" syndrome).

Changing FSA rules to allow unspent balances to carry forward into the next year without being forfeited or subject to taxes would remove the most flawed incentives under current rules. Eligible workers would become more likely to participate in FSA options and to dedicate more funds to them.

Increasing the size of average FSA contributions also would help absorb more of their relatively high administrative costs for claim filing. Ideally, expanded use of smart card technologies by FSA administrators and improved disclosure of comparative price information in the market for out-of-pocket health spending would provide other compensating efficiencies and increased point-of-sale convenience.

Although FSA critics may presume that wealthier workers take greater advantage of current FSA options than less affluent ones, Cardon and Showalter find that is not true. They also conclude that an increase in a worker's level of risk aversion increases the likely amount of their FSA contribution. In that case, FSA benefits operate in a manner similar to stop-loss provisions in standard health insurance policies.[12]

In any case, the full potential of FSAs should be unleashed. Allowing FSA holders to accumulate tax-advantaged funds on a multi-year basis, enabling workers to invest fund balances, and providing full portability as employees change jobs would encourage a further restructuring of private health insurance markets. FSAs could become the primary vehicle for financing medical procedures and health services that involve relatively predictable expenses and are easily foreseeable in the near future.[13]

Value-conscious employers and employees also could insist that insurers "spin off" (not insure) those items for which the typical treatment cost is relatively low compared with the paperwork required to process the claim. Self-financing those items through expanded FSAs would be more efficient than covering them under comprehensive health insurance plans.

Multi-year, portable FSAs also could provide a backdoor route to greater first-party control of health spending decisions for workers who continue to lack access to full-strength MSA products. Even the currently authorized version of FSAs could be cleverly combined with employer-financed HRAs to allow joint employee/employer funding of much larger tax-advantaged health savings accounts to handle higher levels of out-of-pocket spending and encourage greater use of high-deductible insurance coverage.

**Tax Credits**

The last few years of political debate over the relative merits of refundable, fixed-dollar tax credits versus expanded public program coverage for assisting the uninsured have generated a superficial consensus to "do something" without little agreement on which path to take. Rather than simply repeat the steps of others down that well-worn policy path, I would prefer to offer a few cautionary notes regarding what has been overlooked in that discussion and then suggest an alternative approach that both limits and expands the conventional tax credit approach.

First, we should remember that the primary goal of tax policy in this area should not be to steer health care consumers toward financial arrangements that make most

health care spending choices appear to cost significantly less than their market value. Extending the longstanding distortions of the tax exclusion for employer-sponsored group insurance to other forms of health spending may become necessary in a world of third-best and fourth-best policy alternatives, but we should try harder to aim at a version of tax parity for health insurance purchasers that holds the resulting collateral damage to a minimum.

More than fifty years of health policy history should remind us of the costs, as well as the benefits, of the special tax treatment of ESI. The tax exclusion forced many working Americans to accept the only health plan offered by their employer, or pay higher taxes. Job-based tax benefits for health care spending put employers, instead of employees, in charge of selecting health care benefits. They also raised the comparative after-tax price of other non-employer-based insurance alternatives.

The tax exclusion continues to distort health care purchasing choices today by favoring the financing of medical services through insurance and providing the greatest tax benefits for the most costly versions of employer-sponsored coverage. It encourages workers to think that someone else (their employer) pays for their health care, and it reduces their sensitivity to the cost of health insurance choices. It disconnects the consumption decisions of insured workers and their families from the payment decisions of employers and their insurers. Tax subsidies for health insurance overstimulate the demand for health care and, perversely, increase its total cost. Because the current tax subsidy for health insurance is inefficient and unfair, it should be reformed to place individuals, not employers or government, in charge of choosing something as personal as health care.

The best way to remove tax policy distortions in the health insurance market would be to eliminate tax subsidies for employment-based health insurance altogether.

But a broad restructuring of the tax code is not on the agenda for this day, this year, or perhaps even this decade. The next-best policy would be to offer a new federal tax credit option, most likely amounting to 30 percent of the cost of qualified insurance coverage. The tax credit option would not eliminate the current tax exclusion; it would provide a competitive alternative for workers to opt for in place of the tax exclusion. It would encourage a more gradual transition toward other forms of private insurance coverage. The tax credit option also would be made available to other individuals and families that currently do not qualify for the tax exclusion because they lack access to ESI coverage.

Employers that continued to offer ESI should be required to report the value of the employer-financed share of that coverage to individual employees on their regular periodic pay statements and annual W-2 forms. The default setting for such disclosure would assume that workers in employer-group plans are community rated within the firm and the employer contributions for coverage are identical for each worker (such as the periodic equivalent of the firm's per-employee COBRA premium). In the event that employers were allowed to adjust health plan contributions to reflect factors specific to individual workers, they could report those different amounts instead. The new tax credits should be assignable to insurers and advanceable, but not refundable. The maximum tax credit available to any eligible individual would be no greater than that individual's total federal income tax and FICA payroll tax liability (including both the employee and employer shares) for the previous calendar year. Only taxpayers would

receive tax credit ''relief'' for health insurance costs.

The net effect of the above tax reform would be to encourage workers and their families either to move from ESI coverage to individually purchased insurance or to ensure that the ESI plan they select represents the best competitive value they can find.

Even if an employer were no longer "paying" directly for an employee's insurance coverage under an employer-sponsored group plan, the employer still could facilitate delivery of health tax credit assistance through several mechanisms. An employer could choose to include in an employee's gross wages an amount equivalent to what the employee otherwise would have received as the non-taxable employer's contribution to the employee's applicable share of any group coverage offered under the employer's health benefits plan. An employer could "list bill" and allow employees using the tax credit option to pay their individual insurance premiums through payroll deduction (that is, an insurer bills the employer for a list of designated employees who have opted for nonemployer-sponsored coverage). In the latter case, the workers would bear the entire premium, but apply their tax credit to reduce the net payment due.

Congress should consider using the new tax credit option to leverage other market-opening reforms. In that case, consumers wishing to use the tax credit would have to purchase an insurance package that covered a minimum set of health services and included a minimum, but significant, front-end deductible (along with maximum out-of-pocket ''stop-loss'' limits). Qualified insurance policies might provide separately priced guaranteed renewal options in return for exemption from HIPAA's guaranteed renewal

requirements. Those policies also should be exempt from individual state benefit mandates.

New voluntary purchasing pools also could be authorized to accept tax credit funds to pay for such qualified insurance in return for federal preemption of state benefit mandates, fictitious group laws, or rating laws that would otherwise interfere with their operations. Those pools would need to meet certain minimum criteria that include capital and solvency requirements. They would have to provide annual open seasons and be open to all willing purchasers who use the health tax credit option.

Such purchasing pools would have the potential to provide an efficient mechanism for workers to gain a wider choice of health plans than many employers (particularly smaller ones) can offer on their own. Indeed, they might provide effective alternatives to poorly performing employer-selected health plans. For that reason, pool participation should not be limited just to business firm buyers making collective decisions for all their employees. Membership in "voluntary" purchasing pools should reflect the preferences of individual workers and other health care consumers, not just the interests and convenience of employers.

The role of purchasing pools would be to provide a single, stable source of ongoing coverage. They would ease the burden of choosing and buying coverage, particularly for people seeking insurance without the assistance of an employer. Pool administrators would help design benefits packages offered to individual pool participants. They would negotiate contracts and premiums with the health plans choosing to sell to pool members. In short, pool administrators would and should be effective purchasers and advocates on their behalf.

Providing a new tax credit option could jump-start the evolution toward an employee benefits environment in which workers more directly control their healthcare benefits and insurance choices. It would ensure sufficient consumer demand for individually selected insurance arrangements and provide a competitive alternative to ESI coverage.

Any new tax credits for health care should not try to finance comprehensive insurance for all uninsured, low-income Americans. When most refundable tax credit proposals award tax "cuts" to individuals who pay little, or no, federal taxes, they blur necessary policy distinctions between how to set the appropriate level of income-based welfare assistance and how to neutralize the many distortions caused by our complex tax system. The politics of refundable tax credit proposals also have unfortunately steered recent health care debates away from broad, individual-empowerment tax reforms and toward a narrow, cramped version of targeted handouts to smaller slices of the lower-income, uninsured population.

Refundable tax credits combine bad tax policy, bad welfare policy, and bad health policy. They reinforce the mistaken stance of those who argue that cuts in marginal tax rates are somehow "unfair" when they provide most of their benefits to those who pay the largest share of federal income taxes. Refundable credits also are prone to carrying the lumpy baggage of complex income-based, phase-out levels; tight restrictions on the contents of eligible health benefits packages; and narrow rules for eligible insurers.

Making health tax credits refundable would endorse expansion of current

taxpayer-financed ''entitlements'' to health insurance coverage. It would adopt the view that health insurance is a ''merit good'' for everyone and that necessary access to health care cannot be adequately financed without even greater subsidies from taxpayers for insurance coverage. Many lawmakers who salute the remarkable benefits gained from limiting the magnitude and duration of cash assistance to low-income beneficiaries on the welfare rolls nevertheless appear poised to dole out a new round of permanent ''welfare'' checks to the working poor, hidden beneath a refundable health tax-credit label.

For low-income individuals lacking access to health insurance, the better policy solutions include safety net reforms that strengthen state high-risk pools and encourage charitable contributions to provide health services through nonprofit intermediaries. Dollar for dollar, investing in safety net assistance that directly delivers care to the uninsured is more effective and productive than trying to coax them to purchase health insurance with modest tax subsidies.

The current market for charity care operates quite rationally in mimicking the effects of private catastrophic insurance policies. The proportion of health care paid out-of-pocket by the uninsured decreases considerably as utilization and total "spending" increases. Proportionately more charity care is available for uninsured individuals who incur larger medical expenses. And the low-income uninsured with high medical bills (above $10,000) pay about half as much out-of-pocket for their care as do high-income uninsured individuals with similarly sized bills. (The low-income uninsured with such high bills receive 90 percent of their care for free.)[14]

In the long run, improving the quality of education that lower-income individuals receive, expanding their personal control of health care decisions, and reversing

regulatory policies that increase the cost of their health care will yield even greater returns in improved health outcomes.

If Congress nevertheless feels compelled to provide refundable tax credits to lower-income Americans for reasons that blur universal coverage goals with income redistribution objectives, it should first answer the question: Why not simply provide equivalent income support through more targeted delivery of fungible cash vouchers and then concentrate on implementing broader health policy reforms that improve the availability in private markets of more affordable health insurance purchasing options? Sorting out the parameters of income support policies from the opportunities for broader health care market reform would target better the appropriate policy instruments for each of these distinct objectives.

Refundable tax credit subsidies directed primarily at uninsured lower-income workers obviously will provide some increase in overall health insurance coverage. But they still will need to be financed at a higher enough rate – perhaps 50 percent or more of premiums for relatively limited benefits – to have any substantial effect on levels of uninsurance in the target population. Fixed-dollar credits might be easier to score for budget purposes and to provide higher coverage take-up rates, but proportional tax credits would be more effective in targeting uninsured individuals at the highest risk and in the greatest need.

In any case, new tax subsidies for health insurance purchasing should pass through directly to individual consumers, rather than be used as initial sweeteners to induce employers to maintain or establish job-based coverage. The current tax code already allows employers sufficient opportunity to deduct the full cost of providing group

insurance coverage to their employees, if they chose to do so, as an ordinary business expense.

**Other Policy Tools to Help the Uninsured**

The inevitable tendency of conventional politics is to latch on to seemingly facile fixes for chronic and complex problems by channeling seemingly "free" sources of budget dollars into narrow program silos. But attempts to provide sufficiently generous tax credits for the uninsured, with an end goal of near-universal health insurance coverage, will quickly bump up against other competing claims on public resources. Expanding the availability of MSAs and acknowledging the tradeoffs between catastrophic insurance protection and subsidies for early-dollar health spending would allow us to accomplish more by aiming to do less. Other promising policy tools beyond the scope of today's hearing might include providing "competitive federalism" incentives to deregulate state-based insurance regulation, facilitating the convergence of various tax-advantaged savings vehicles for future health care needs, and clearing away remaining policy barriers to consumer-driven health care options that can travel through all terrains.[15]

It would also help to keep the chronic problem of the "uninsured" in perspective. Last September's annual Census Bureau estimate of the number of uninsured people in the U.S. found that Americans lacking health coverage during 2001 increased by 1.4 million, to 41.2 million, of 14.6 percent of the population. That number by itself was disappointing and needs to be improved. However, it occurred during a year in which an economic recession began, it represented a smaller share of the population being uninsured than was the case from 1992 through 1998, and more than half (approximately

58 percent) of the year-to-year increase in the uninsured came from members of households with annual incomes of $75,000 or more.

Our society may well decide to spend ever greater shares of our nation's resources on health care in future years – for the uninsured, perhaps, but certainly for the worried well of the middle class – as long as someone can be found somewhere to foot the bills. But American consumers will receive more *value* for each dollar they spend only if the distorting effects of government's multiple roles as a regulator, purchaser, and subsidizer of health care are reduced. Our objective should be neither to artificially keep spending levels higher, nor lower, than their market-determined costs. Instead, we should allow individual consumers to seek the best value that balances their spending preferences and priorities with the resources that they can command.

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[1] U.S. General Accounting Office, "Private Health Insurance: Small Employers Continue to Face Challenges in Providing Coverage," GAO-02-08, October 2001, pp. 13-15.
[2] Ibid., pp. 10-16.
[3] Ibid., pp. 16, 17.
[4] Tom Miller, "Improving Access to Health Care without Comprehensive Health Insurance Coverage: Incentives, Competition, Choice, and Priorities," in *Covering America: Real Remedies for the Uninsured,* ed. E.K. Wicks and J.A. Meyer. Washington: Economic and Social Research Institute, 2002.

[5] See, e.g., Martin Feldstein. *Hospital Costs and Health Insurance.* Cambridge, MA, and London: Harvard University Press, 1981, pp. 88, 201-03, 239-44; Martin Feldstein. "The Welfare Loss of Excess Health Insurance." *Journal of Political Economy* 81 (2) (1973): 251-80. See also Edgar A. Peden and Mark S. Freeland. "A Historical Analysis of Medical Spending Growth, 1960–1993," *Health Affairs 14* (2) (1995): 236–47 (finding that about half the growth in real per capita medical spending from 1960 to 1993, and two-thirds of its growth from 1983 to 1993, resulted from either the level or growth of insurance coverage).

[6] Jason S. Lee and Laura Tollen, "How Low Can You Go? The Impact of Reduced Benefits and Increased Cost Sharing," *Health Affairs* web exclusive, June 19, 2002, www.healthaffairs.org/WebExclusives/Lee_Web_Excl_061902.htm .
[7] Dana P. Goldman, Joan L. Buchanan, and Emmett B. Keeler, "Simulating the Impact of Medical Savings Accounts on Small Business," *Health Services Research* 35 (1) (2000): 53–73.
[8] Matthew J. Eichner, Mark B. McClellan, and David A. Wise, "Insurance or Self-Insurance? Variation, Persistence, and Individual Health Accounts," National Bureau of Economic Research Working Paper no. 5640, June 1996.
[9] Michael T. Bond, Mary W. Hrivnak, and Brian P. Heshizer, "Reducing Employee Health Expenses with Medical Savings Accounts," *Compensation and Benefits Review* 28, no. 5 (September–October 1996): 51–56.
[10] James H. Cardon and Mark H. Showalter. "An Examination of Flexible Spending Accounts," *Journal of Health Economics* 20 (6) (2001): 935-54.
[11] Ibid., p. 944.
[12] James H. Cardon and Mark H. Showalter, "Flexible Spending Accounts as Insurance," *Journal of Risk and Insurance* 70 (1) (2002): 49-50.

[13] Cardon and Showalter suggest that such items might include orthodontic care, prescription drugs for chronic conditions, dental care, optical care, and other elective health services. "An Examination of Flexible Spending Accounts," pp. 936, 953.
[14] Bradley J. Herring. "Does Access to Charity Care for the Uninsured Crowd Out Private Health Insurance Coverage?" Yale University Institution for Social and Policy Studies working paper. September 7, 2001, p. 10.
[15] See Miller, 2002.

*Congressional Testimony*
*Provided by Kim Snyder*
*Chairman of the Lehigh Valley Chamber of Commerce*
*To the Subcommittee on Tax, Finance and Exports*
*of the Committee on Small Business*
*of the United States of House of Representatives*
*May 6, 2003*

**Mr. Chairman, esteemed members of the Committee, and interested guests; I am Kim Snyder, Chairman of the Lehigh Valley Chamber of Commerce. The Lehigh Valley Chamber of Commerce is the second largest, fastest growing chamber in the state of Pennsylvania. I am very grateful for this opportunity to speak to you today in representation of our membership of 4,000, nearly 90% of which is small business.**

**As you are aware, it is estimated that more than 40 million Americans presently have no health insurance. More than 1 million of those are my fellow Pennsylvanians.**

**The Lehigh Valley Chamber stands firm in its belief that a compendium of solutions should be offered to enable small businesses the opportunity to provide quality and affordable health care to the estimated 70 percent of uninsured who are working adults, dependent of working adults or those recently unemployed.**

**Our research of this matter, both formal as well as informal, shows an urgent need of the business community in lessening restrictions which are presently placed on health care options, such as Medical Savings and Flexible Spending Accounts.**

**For example, Medical Savings Accounts have been demonstrated to provide workers with an affordable means to provide health care for those workers and their families. MSAs allow for the establishment of a tax-exempt account dedicated for medical expenses and require a high-deductible health plan**

**to cover any instance of catastrophic illness or injury. Further, MSAs have the distinct advantage of employer portability and the return of yearly monies invested but not spent.**

**While these benefits are valuable to many, others seeking alternatives to health care options are precluded from participation in MSAs due to restrictions on enrollment, deduction allowances and contribution source requirements. Important to note as well is the negative enrollment effect that the sustained "pilot" status of the MSA program bears. It is believed that due to continued program extensions, the marketing of the program is not as successful as it could be, which creates a consumer lack of education and ultimate hesitancy in the option. Therefore, the Lehigh Valley Chamber of Commerce supports the:**

- **Permanent Federal acknowledgement of MSAs;**

- **Expansion of MSAs to include all individuals and families;**
- **Allowing of contributions to be made from both employers and employees.**

**Flexible Spending Accounts, unlike MSAs, are always employer established, and allow contributions of up to $4000 (pre-tax) per year. FSAs can also offer eye, dental and dependent care coverage. It is important to note that also unlike MSAs, invested monies are not returned at year-end. As this is the case, there is no re-invest option to set aside for future medical expenses. This restriction needs to be changed so that employees may better prepare for their future health care cost needs.**

**Lastly, the Lehigh Valley Chamber of Commerce supports wholeheartedly the expansion of tax credits to small businesses who provide health care to their employees. We**

**believe strongly that by providing financial incentives to our Nation's largest collective private workforce, we will be supporting the efforts of business owners as they strive to provide the most valuable employee benefits of all; that of health, security and well-being.**

**Mr. Chairman, Congressmen, that concludes my testimony. Before I close however, I would like to once again thank you for your interest and attention to the very important matter of the uninsured, which affects much of our Nation's citizenry. Be assured that we at the Lehigh Valley Chamber of Commerce will continue to advocate on behalf of our small businesses and will continue to assist you in whatever way possible.**

**National Association for the Self-Employed**

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**Testimony of**

**Keith Hall, Member of**
**The National Association for the Self-Employed**

**House Small Business Committee**
**Subcommittee on Tax, Finance and Exports**

**"Overcoming Obstacles Facing the Uninsured"**

**May 8, 2003**

I would like to thank you Mr. Chairman, and Subcommittee members for the opportunity to be here today. My name is Keith Hall. I am a certified public accountant and I am a small business owner from Dallas, Texas. I am here representing the National Association for the Self Employed, an organization of which I have been a member for over 10 years.

One of the main goals of the NASE is to combine the influence of the over 250,000 self-employed individuals and micro-business owners they represent so that the voice of micro-business in general can be heard. A voice that doesn't ask for special favors or tax incentives. A voice that only asks to have the same opportunity for success afforded to big business. Today, this vital segment of the small business population within our nation numbers more than 18 million. Micro-businesses are the drivers of America's economic engine, creating well over a third of all new jobs to the economy between 1998 and 1999. The last U.S. Census reported that these firms employ more than 12.3 million workers with a total annual payroll of more than $309 billion.

The chief impediment that micro-businesses and the self-employed are facing as they try to stay afloat in this time of economic stagnation is the ever-increasing costs of health coverage. The state of health care among the nation's self-employed and micro-businesses is critical. According to a June 2002 study released by the NASE entitled "Affordability in Health Care: Trends in American Micro-Business," seven in 10 micro-business owners report they do not provide any type of health care coverage to eligible employees nor have coverage for themselves. Costs are cited as the chief reason for this trend. Participants in the study say the situation is worsening as health insurance premiums for micro-businesses are increasing at double-digit rates while insurance benefits and plan choices are decreasing.

Thus, I am here today, on behalf of the NASE, to voice its strong support for health care tax credits and also H.R. 1873, the Self-Employed Health Care Affordability Act of 2003, which has as its only goal, to provide small business with the same opportunity for success as big business in affording quality health coverage.

As with most of us here, I wear a lot of different hats. I am a father and a husband. I run a small business and I am the treasurer of my Sunday school class. I serve on two Corporate Boards of Directors and I am an officer of my kid's high school booster club. But today, my hat is concerned about the cost of healthcare for my family. I currently pay approximately $600 a month for health insurance or a little over $7,000 per year, which sadly enough is reasonable in this current healthcare climate where self-employed individuals are known to pay up to $13,000 for family coverage. When it comes time to prepare my tax return, those premiums are deductible for the purposes of income tax, but they must be included on the front page of my tax return because I am self employed. This means that the premiums are not included on the business portion of my tax return and therefore, are not deductible in calculating the Self Employment tax that I must pay. Other business owners, big business, have the opportunity to pay for their health insurance premiums before any tax calculation is applied to the earnings of their officers and employees. So what does that all mean. Before anything else is taken into consideration, the cost of my health insurance is up to 15.3% higher than the guy next to me solely because I am self-employed. He may have the same size family, the same health concerns, the same medical history and even the same weight problem that I have. Everything can be exactly the same, but I will still pay 15% more for my coverage that he does simply because the Internal Revenue Code does not allow me to fully deduct my health insurance premiums. The self-employed are the only segment of the business population that pays this extra tax on health insurance.

Image going to the movie and the guy in front of you pays $14.00 for two tickets for he and his wife. When you get to the window, the clerk says that will be $16.00 because you own your own business. The same movie, the same seat, the same popcorn, but you have to pay 15% more. It doesn't make sense.

This cost differential is not designed to influence the buying habits of the consumer such as a cigarette tax or alcohol tax. The cost differential is not designed to provide financial assistance such as the Earned Income Tax Credit or the Child Tax Credit, I believe the cost differential is solely an inequity in the Tax Code that has been overlooked, until now.

I am certainly not a health care expect nor am I an insurance expert. However, my bias is that providing affordable health care in the United States in 2003 is a tough issue. There are many pieces to achieving this goal that are very complicated. Health care credits, negotiating cost control with health care providers, access for the currently uninsured and uninsurable and so much more. Very few of these issues are self-contained, but each has an impact on the other with complexities on top of complexities, with virtually no easy answers. The Self-Employed Health Care Affordability Act (H.R. 1873) is an easy answer.

The members of this committee, and on are a larger scale, the members of the House and the Senate as a whole, are asked to make tough decisions everyday. As an average American citizen, I know that I greatly appreciate the effort that you extend in making those tough decisions. I can only guess how refreshing it must be when an easy decision comes along. From where I stand, H.R. 1873 is an easy decision mixed up in a very difficult issue. Providing the small business owner with the same tax treatment that the big business already has is the right thing to do and will have an immediate impact on the affordability of health care for millions of self employed business owners. There is no reason why my movie ticket should cost more just because I am self-employed and the same goes for my health insurance.

The NASE also strongly supports health tax credits as a viable solution to begin addressing the larger issue of the uninsured in our nation. Nearly 80 percent of the respondents to the NASE survey say they would be likely to purchase health insurance for their employees if they were given tax credits. The NASE supports the S.A.V.E. Act sponsored by Representatives Kay Granger and Albert Wynn. Yet, we are aware that there is no silver bullet that will cure the issues within our nation's health care system. Thus, the National Association for the Self-

Employed strongly supports continued efforts to find proactive solutions, rather than reactive, to address the root causes of continual health insurance premium increases and lack of quality health coverage.

Once again, I would like to say thank you on behalf of the NASE and for myself for the opportunity to be here today. And on a personal note, I would like to extend my personal gratitude to the members of this Subcommittee and the House and Senate as a whole for working so hard to keep this country strong and healthy and helping people like me afford it.

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*May 8, 2003*

**Testimony of Edwin Park**
**Senior Health Policy Analyst, Center on Budget and Policy Priorities**

**Hearing on Overcoming Obstacles Facing the Uninsured: How the Use of Medical Savings Accounts, Flexible Spending Accounts and Tax Credits Can Help**

**Before the Subcommittee on Tax, Finance and Exports**
**House Committee on Small Business**

I appreciate the invitation to testify today. I am Edwin Park, a Senior Health Policy Analyst at the Center on Budget and Policy Priorities. The Center is a non-profit policy institute here in Washington that specializes in fiscal policy and in programs and policies affecting low- and moderate-income families. The Center does not hold (and never has received) a grant or contract from any federal agency.

My testimony today focuses on two tax proposals related to health care that are the subject of today's hearing: an expansion of Medical Savings Accounts (MSAs) and refundable tax credits for the purchase of health insurance primarily in the individual market. These proposals are part of the Administration's fiscal year 2004 budget and are intended to expand coverage to the uninsured. Both raise serious concerns.

As the economic downturn continues and private health insurance premiums rise at the fastest rate since 1990, small businesses are finding it more difficult to provide health insurance. Many small businesses may be forced to leave their workers either underinsured or without coverage entirely. We welcome effective initiatives that would help small businesses offer (or continue to provide) health insurance. However, we view MSAs and individual tax credits as ill-advised approaches for solving the problems of the uninsured.

The chief concern with both proposals is that they could undermine the traditional employer-based health insurance system through which the vast majority of Americans obtain their health insurance and place workers' access to affordable and comprehensive health insurance at risk. This is because proposals for MSAs and individual tax credits pose a significant risk of substantially increasing the premium costs of traditional employer-based health insurance over the long-run. As a result, they could force a number of employers including small businesses to have no choice but to drop coverage entirely, thereby adding many of their workers — especially those who are older and sicker — to the growing ranks of the uninsured.

If one wishes to address the problem of the uninsured through the tax code without these adverse effects, a superior alternative would be a tax credit provided to small businesses to help subsidize the cost of their health insurance premiums. Such a credit would have the benefit of strengthening — not undermining — the ability of small businesses currently providing

traditional health insurance to continue to do so. It would also encourage small businesses now unable to offer health coverage to begin to provide health insurance benefits. This proposal would be most effective if the credit was targeted to the small businesses that most need additional assistance; small businesses with the fewest workers *and* a substantial number of low-wage workers are the ones least able to provide health insurance to their employees.

### Small Businesses and Health Insurance

While virtually all firms with more than 200 employees provide health insurance coverage to their workers, small businesses are less likely to offer health insurance coverage. In general, the smaller the firm, the less likely the business is able to offer health benefits to its workforce.

While the proportion of small businesses offering health benefits increased substantially during the late 1990s, the recent economic downturn and rapidly increasing health insurance premiums have subsequently eroded some of this progress. Health insurance premiums are now rising at the fastest rate since 1990. According to the Kaiser Family Foundation and the Health Research and Education Trust, health insurance premiums for employers increased on average by 12.7 percent between 2001 and 2002. Premiums increased even faster for small businesses. Among firms with fewer than 25 workers, premiums rose nearly 15 percent.[1]

Fewer small businesses are now offering health benefits. In 2002, 61 percent of all firms with fewer than 200 workers provided health insurance, down from 67 percent in 2000. Among firms with fewer than 10 workers, only 55 percent offered health benefits (dropping from 60 percent in 2000). Among firms with 10-24 workers, 74 percent offered health benefits (as compared to 79 percent in 2000).

Small businesses that employ many low-wage workers appear to be the firms most unable to offer health insurance coverage to their employees. According to a Kaiser Family Foundation survey of small businesses with fewer than 25 workers, in 2001, less than half of small firms (48 percent) whose workers had an average wage of less than $2,200 per month offered health insurance. In contrast, 75 percent of small firms with workers who had an average wage above $2,200 per month included health benefits.[2] In another analysis, the Commonwealth Fund looked at low-wage workers employed by small businesses with fewer than 25 workers. In 2001, only 36 percent of workers who earned less than $10 per hour were offered health insurance coverage through their employers, as compared to 67 percent of workers earning more than $15 per hour. The Commonwealth Fund study found that as a result, 37 percent of workers earning less than $10 per hour in small businesses were uninsured.[3]

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[1] Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2002 Annual Survey*, September 2002.

[2] Kaiser Family Foundation, *National Survey of Small Businesses*, April 2002.

[3] Sara R. Collins, Cathy Schoen, Diane Colasanto and Deirdre A. Downey, *On the Edge: Low-Wage Workers and Their Health Insurance Coverage: Findings from the Commonwealth Fund 2001 Health Insurance Survey*, the Commonwealth Fund, April 2003.

## Analyzing Approaches to Expanding Coverage to the Uninsured

Let us consider in greater detail two of the approaches that are the subject of today's hearing: an expansion of Medical Savings Accounts (MSAs) and refundable tax credits for the purchase of health insurance primarily in the individual market. The Administration included these proposals in its fiscal year 2004 budget.

Supporters of MSA expansions may argue that more small businesses not currently offering any health insurance benefits would now be able to offer MSAs. Supporters of individual tax credits may argue that individual workers in those small businesses unable to provide health insurance could purchase coverage through the individual market. The evidence suggests, however, that such gains in coverage would not occur. While both proposals are intended to expand coverage to the uninsured, any gains in coverage are likely to be outweighed by the adverse effects these proposals impose on the traditional employer-based health insurance system.

Small businesses now offering health coverage may find that these proposals would make their premiums for traditional health insurance unaffordable and leave them no choice but to drop coverage entirely. Many workers, especially those who are older and sicker, may become underinsured or join the growing ranks of the uninsured. Moreover, few older and sicker workers would be able to obtain insurance in the individual market even if they received a tax credit.

A superior alternative to these approaches would be a targeted tax credit provided to small businesses to help them furnish health insurance to their workers.

### Expansion of Medical Savings Accounts

Established under a national demonstration project scheduled to expire at the end of 2003, MSAs are tax-advantaged personal savings accounts that are maintained in conjunction with high-deductible health insurance policies.[4] Funds in MSAs may be used to help pay for health care expenditures that the high-deductible polices do not cover. These funds also may be retained unused in the MSA accounts and placed in investment vehicles such as stocks and bonds, with the investment earnings accumulating tax-free in the accounts. Eventually, the funds in these accounts may be withdrawn not only for medical purposes but also for *non*-medical purposes such as retirement. As a result, MSAs can be used as a tax shelter.

MSA use currently is limited under the demonstration project. MSAs may be set up by self-employed individuals and people employed at small businesses. Small businesses with fewer than 50 workers may offer MSAs and high-deductible plans and make tax-advantaged

[4] For more analysis of MSAs, see Edwin Park and Iris J. Lav, *Proposed Expansion of Medical Savings Accounts Could Drive Up Insurance Costs and Increase the Number of Uninsured*, Center on Budget and Policy Priorities, April 30, 2003.

deposits into their employees' MSA accounts, or individuals employed at such firms may establish MSAs themselves and make their own deposits into them. Deposits into MSAs by individuals are tax deductible.

It is important to emphasize that small businesses are already able to participate in the MSA demonstration project under current rules. Yet, the legitimate problems small businesses are facing in providing health insurance — including affordability — remain and are growing. If MSAs were truly the answer for small businesses, more small firms would be providing such coverage to their employees instead of struggling to provide traditional health insurance plans.

Nonetheless, the Administration has proposed to significantly expand MSAs. Proponents of large-scale expansion argue that it would increase health insurance coverage and thereby reduce the ranks of the uninsured. But most health analysts disagree. Leading analysts and research institutions have concluded that the effect is likely to be the reverse.

In particular, an array of analyses by respected research institutions has found that widespread use of MSAs could adversely affect the employer-based health insurance market by causing the cost of traditional, low-deductible insurance coverage that provides comprehensive benefits to spiral. As a result, significant numbers of employers might no longer be able to afford to offer traditional plans. The loss of such plans would place in jeopardy large numbers of older and sicker employees, who particularly need such coverage.

The national MSA demonstration project has produced no evidence to dispel the disturbing findings that emerge from this body of research. Despite these strong warnings, the Administration's budget proposes to repeal most current protections and limitations related to MSAs, to make MSAs more lucrative as tax shelters for affluent, healthy individuals — and hence more attractive to such individuals — and to allow unlimited expansion of MSAs across the country. These MSA expansions have long been endorsed by insurance companies that sell MSA policies and conservative policy institutions. The MSA proposals would cost the Treasury $5.7 billion over ten years, according to the Joint Committee on Taxation.

The research on MSAs suggests that strong caution should be exercised with respect to these proposals. The risks that the proposals present stem from the following factors.

- **Widespread use of MSAs could jeopardize coverage for substantial numbers of Americans in traditional health insurance by causing premiums for traditional insurance to rise markedly; research by the RAND Corporation, the Urban Institute, and the American Academy of Actuaries has found that premiums for traditional insurance could *more than double* if MSA use becomes widespread.**

MSA plans operate in conjunction with high-deductible insurance policies. Participants can use funds they or their employers have deposited in their Medical Savings Accounts to cover part of the out-of-pocket medical costs that the participants incur as a result of the high-deductible policies.

People who incur substantial medical costs generally do not fare well under such arrangements. To obtain health care services that normally would be covered under traditional

comprehensive insurance, these people must spend a significantly greater portion of their own money. If they do not have significant income or assets, they may not be able to afford these costs and may be forced to forgo needed health care treatments.

By contrast, people who are quite healthy can find such arrangements attractive; if they use little health care, they can accumulate funds in their MSAs on a tax-advantaged basis, since earnings accumulate tax free in the accounts. In addition, as noted above, any funds that individuals deposit in their MSAs are tax deductible. Healthy people who are affluent can find this particularly advantageous, since they are better able to afford to make large deposits into MSAs. The tax benefits that MSAs provide are worth the most to people in the higher tax brackets.

These features of MSAs make them especially prone to what economists and health analysts call "adverse selection," under which healthier people abandon one type of health insurance for another. When this occurs, the people who remain in the traditional type of insurance constitute a group that is less healthy — and hence more expensive, on average, to insure. If MSAs are opened up for widespread use, then young, healthy people who anticipate facing few health care costs in the year ahead may choose to participate in them in substantial numbers. But older and sicker people who judge they are likely to incur significant health care costs would tend *not* to participate; they would be better off remaining in traditional health insurance, which typically has much lower deductible amounts, includes relatively low co-payments, and provides a comprehensive set of benefits.

If MSA use become widespread and substantial numbers of healthier people choose MSAs and high-deductible policies while less healthy people do not, the pool of people who remain in traditional comprehensive health insurance will be sicker, on average, and more expensive to insure than it is today. As a result, premiums charged to employers for comprehensive insurance policies will have to increase, perhaps by very large amounts.

- **Despite these risks, the Administration's proposals are designed to lead to substantially expanded MSA use, through elimination of all limits on the use of MSAs and changes in MSA rules that would make MSAs more lucrative as tax shelters.**

The Administration's budget proposes to make MSAs available to any individual who wishes to participate. This is a sharp departure from current practice, under which only workers who are in small businesses or are self-employed can use a MSA and no more than 750,000 MSA policies may be written nationwide. In fact, these limits were put into place in order to minimize, in part, the risk of adverse selection. Yet, under these proposals, any individual could use an MSA, and any employer — rather than just small firms — could offer them.

This would open up MSAs on a broad basis to affluent, healthy individuals, for whom they could be quite valuable as tax shelters. MSAs bear strong similarities to tax-deductible Individual Retirement Accounts in that the deposits an individual makes into these accounts are tax-deductible and the earnings that accumulate in the accounts are tax-free. The funds in the account are never taxed as long as they remain in the account or are withdrawn for medical

purposes. (The funds are subject to taxation if withdrawn for non-medical purposes, just as funds in tax-deductible IRAs are subject to taxation when withdrawn.)

But MSAs differ from IRAs in one key respect — *there are no income limits on MSAs that prevent wealthy people from making tax-deductible contributions to them* and using them as a way for accumulating tax-free earnings on investments. This is of particular significance because the higher an individual's tax bracket, the greater the tax benefit an MSA provides.

By opening MSAs up for widespread use, the Administration's proposals thus would enable high-income individuals to circumvent the IRA income limits by using MSAs for the same purpose — as tax shelters to accrue substantial assets over time on a tax-advantaged basis. It should be noted that at retirement, funds can be withdrawn from MSAs penalty-free for *non*-medical purposes.

In addition, the Administration's proposals would enlarge the value of MSAs as tax shelters by increasing the amount that can be deposited in an MSA each year on a tax-deductible basis.

If MSAs become universally available and the amount of money that can be sheltered from taxation though MSAs is increased, the tax advantages of MSAs to healthy higher-income taxpayers are likely to be marketed widely by banks and investment houses — much as IRAs are advertised — leading to further growth in MSA use.

The likely result of the Administration's proposals would be substantially increased MSA use. That, in turn, would likely drive up premiums in the traditional health insurance market for all employers including small businesses.

- **Another reason that MSA use is likely to become more widespread under the Administration's proposals is that these proposals would be likely to lead a substantial number of employers to substitute MSAs and high-deductible insurance policies for traditional comprehensive employer-based insurance.**

Faced with rising health care costs, some large employers recently have begun offering a package of health savings accounts that are broadly similar to MSAs, coupled with high-deductible policies, instead of offering traditional comprehensive insurance. Employers offering this package have concluded that doing so saves them money. The appeal of such packages is currently limited, however, because these health savings accounts lack the tax advantages of MSAs. Individuals cannot make tax-deductible contributions into them. Nor can they withdraw funds from these accounts upon retirement for *non*-medical purposes.

That such accounts are beginning to be offered by large employers even though the accounts lack the tax attractions of MSAs suggests that if MSAs were made universally available and their tax-shelter benefits enlarged, as the Administration is proposing, substantial numbers of employers might begin offering MSAs and high-deductible policies.

There is yet another reason that some employers might replace their current insurance arrangements with MSAs coupled with high-deductible policies. Under current law, employers cannot provide a different set of health benefits to higher-income executives than to lower-paid rank-and-file workers. To provide benefits that are attractive to their managers, firms generally must provide low-cost, comprehensive coverage to all of their workers. With MSAs, however, employers could provide less costly, less generous high-deductible plans tied to MSAs without worrying as much that such plans might encourage executives to seek jobs elsewhere that offer better health benefits. High-income managers and executives could use their MSAs as tax shelters by making substantial contributions to the MSAs on a tax-deductible basis. Since these individuals would have the ability to accumulate significant amounts in their MSAs — and the value of the MSA tax break is greatest for those in the top tax brackets — these tax benefits could make up for the increases in deductibles and other reductions in covered benefits that the executives could face under the high-deductible plans their employers might substitute for more comprehensive coverage. (For rank-and-file workers — and especially less healthy workers — such a change would generally be harmful; those workers would lose comprehensive low-deductible insurance and receive, in its place, a tax break of little value to them.)

- **Finally, if this proposal becomes law, growing numbers of employers who do not initially seek to replace traditional comprehensive health insurance with MSAs may ultimately conclude they have little choice but to scale back comprehensive coverage significantly or eliminate it.**

If MSAs are broadly available, and if health care costs and thus the premium charges that employers pass through to their employees continue to rise, growing numbers of healthy individuals may withdraw from regular employer-based plans to escape the mounting charges and to take advantage of the tax breaks that MSAs provide. If this occurs, it is likely to induce growing numbers of employers at least to offer MSAs and high-deductible policies as an option.

But once substantial numbers of younger, healthier workers withdraw from an employer's comprehensive coverage plan — either to purchase a high-deductible policy and set up an MSA on their own or to participate in an employer-sponsored MSA/high-deductible package — a death spiral can set in for the employer's comprehensive coverage option. The withdrawal of younger and healthier workers from comprehensive insurance causes the employees left in traditional insurance to become a group that is less healthy on average and therefore more expensive to insure. As a consequence, such employers are likely to feel compelled either to raise to still-higher levels the premium co-payments their employees must make for comprehensive insurance, thereby driving still more of the healthier employees out of comprehensive coverage, or to cease offering comprehensive coverage altogether.

In short, approval of the Administration's MSA expansion may ultimately lead to comprehensive employer-based group insurance becoming less affordable and less widely available. That would cause more people, especially those who are older and sicker and most in need of traditional comprehensive insurance, to become underinsured or uninsured. These adverse effects are likely to outweigh substantially any modest gains in coverage that an MSA expansion otherwise might produce.

**Tax Credits for Health Insurance in the Individual Market**

As part of its fiscal year 2004 budget, the Administration has proposed to provide a refundable tax credit to individuals and families for the purchase of health insurance in the individual health insurance market.[5]

The tax credit would be available for the purchase of health insurance in the individual market for individuals and families who do not participate in employer-based coverage or public health insurance programs. The credit would equal up to $1,000 for individuals and up to $3,000 for families with children, with the full credit being available to individuals with incomes of less than $15,000 per year and families with incomes below $25,000. The tax credit would phase down as income rose above these levels and would phase out entirely when income reached $30,000 for individuals and $60,000 for a two-parent family of four. According to the Joint Committee on Taxation, the proposal would cost $64 billion over 10 years (the Administration estimates the cost at $89 billion). The proposal accounts for a large percentage of the new federal resources the Administration is proposing for the uninsured.

While the tax credit would result in some currently uninsured individuals gaining insurance (including some individuals working for small businesses that do not offer health benefits currently), the proposal is highly controversial. It poses substantial risks. In particular, the tax credit could materially weaken the employer-based health system through which the vast majority of insured Americans obtain their health insurance coverage and could cause some currently insured people — particularly people who are older or are in poorer health — to lose insurance altogether or to have to pay exorbitant amounts to retain insurance.

- **The availability of the tax credit could lead some employers to cease providing coverage to their workers and could induce many new employers not to offer coverage.**

Analysts from M.I.T., the Kaiser Family Foundation, and the Urban Institute have found that enactment of a tax credit of this nature would encourage some firms not to offer health insurance coverage to their employees because the firms would know their workers could now get a tax credit to purchase coverage in the individual market. Substituting the purchase of health insurance in the individual market for group coverage through an employer, however, would seriously disadvantage older and less healthy workers. In most states, insurers can vary premiums for health insurance policies offered in the individual market on the basis of age and medical history and can refuse to cover people entirely. Many older and less healthy workers would generally have to pay far more than the amount that the tax credit would provide to secure coverage in the individual market or would not be able to obtain coverage at all because of their health status.

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[5] For more analysis of the tax credit proposal, see Edwin Park, *Administration's Proposed Tax Credit for the Purchase of Health Insurance Could Weaken Employer-Based Health Insurance*, Center on Budget and Policy Priorities, Revised April 22, 2003.

- **The tax credit could institute an "adverse selection" cycle that substantially increases the costs of employer-based coverage.**

Under the Administration's proposal, workers whose employers do offer coverage and require their employees to pay a share of the premium would be able to opt out of employer-based coverage and instead use their tax credits to purchase insurance in the individual market. Such a move could be attractive to young, healthy employees; they may be able to purchase individual policies for which the tax credit could cover up to 90 percent of the cost, which often would be a larger percentage of the cost than their employer would cover. But if these young and healthy workers opt out of employer coverage, the pool of workers remaining in employer plans would become older and sicker, on average, which in turn would drive up the costs of employer-based insurance and further raise the amounts that both employers and the employees remaining in these plans must pay for insurance.

This phenomenon — known as "adverse selection" — could then induce additional younger, healthier workers to abandon employer-based coverage and use their tax credits instead, because the departure of the first wave of younger, healthier employees would have caused premiums for employer-based coverage to rise. In this way, a vicious cycle could be set in motion. The increase in premiums for employer-based coverage that ultimately could occur could induce many employers either to cease offering health insurance or to increase substantially the amounts their employees must pay for insurance. The end result would likely be that many older and less healthy individuals would eventually lose their employer-based coverage and become uninsured or underinsured or have to pay exorbitant amounts for decent coverage.

Intensifying the risk that many firms might not offer coverage is the recent return of a high rate of inflation in health care costs, which are now rising at double-digit rates. As a result, fewer firms, especially small businesses, are offering health insurance coverage to their employees. Institution of the tax credit could provide a further incentive for some employers, especially small businesses seeking to cut costs, to drop or not to institute coverage for their workforce.

- **Older and sicker individuals likely would be unable to secure adequate health insurance in the individual market without paying exorbitant amounts.**

The individual market is generally unregulated. Under the Administration's proposal, a family containing older or sick members could find itself excluded from coverage in the individual market or charged premiums that are unaffordable, even with a $3,000 tax credit. Alternatively, such a family could be offered a plan that is affordable but does not provide coverage for a variety of significant medical conditions. Many plans in the individual market do not offer comprehensive coverage. They may require high deductibles, impose significant cost-sharing, and provide minimal benefits.

The Administration says its proposal responds to this concern by allowing tax-credit recipients to buy coverage through high-risk pools and private purchasing pools. The success and scope of these mechanisms, however, has been quite limited. Even with some federal and

state funding, participation is often low, premium costs are substantial, and the health insurance benefits provided can be restricted to a fairly narrow range of services. Moreover, policies available through high-risk pools often impose high deductibles and cost-sharing or exclude coverage of pre-existing conditions for a lengthy period of time.

The Administration's proposal would permit states to allow certain individuals also to use their tax credits to buy into comprehensive public coverage. It is uncertain, however, how many states would elect this option and open their Medicaid and SCHIP managed care plans to tax-credit recipients. Because the people most in need of buys-in to public coverage tend to be sicker, high-risk individuals unable to obtain coverage in the individual market, adding these individuals to the current Medicaid and SCHIP managed care pools (which primarily enroll relatively healthy families and children) could increase Medicaid and SCHIP costs. Most elderly and disabled beneficiaries remain in fee-for-service Medicaid.

- **The tax credit would be of inadequate size to make health insurance affordable for many low- and moderate-income families.**

Health insurance can be expensive. According to the General Accounting Office, the mid-range premium for family insurance in the non-group market exceeded $7,300 in 1998. Even without factoring in the increases in health insurance premium costs since 1998, a family with income of $25,000 that receives a $3,000 tax credit would have to expend 15 percent or more of its gross income to purchase insurance at this price. Furthermore, more recent studies have found that with a $1,000 tax credit for individuals, older individuals may have to spend one-third of their income to purchase comprehensive health insurance in the individual market. In some higher-cost geographic areas, premiums could consume still-greater percentages of an individual's or family's income. Studies indicate that such expenditure levels are substantially beyond what most low- and moderate-income families can afford. Yet, as discussed earlier, many of the uninsured workers in small businesses have low wages and are not likely to have available the necessary financial resources to afford health insurance in the individual market.

In addition, the value of the tax credit is likely to erode over time. The Administration's proposal would index the full credit amount annually by the medical care portion of the Consumer Price Index which, historically, is substantially lower than the growth in overall health spending or health insurance premiums. For example, in 2002, the medical care portion of CPI was five percent while average employer-based health insurance premiums rose 12.7 percent. As a result, in some years, insurance premiums could increase by more than two and a half times faster than increases in the value of the tax credit. In the case of small businesses that tend to experience greater than average premium cost increases, premiums could rise nearly three times faster.

- **The tax credit would not be a cost-effective and well-targeted approach to reduce the ranks of the uninsured, since the large majority of those who would use the credit already have insurance.**

Analysts from M.I.T. and the Kaiser Family Foundation have estimated that under this or similar tax credit proposals, more than two-thirds of those using the tax credit would be people

who already are insured. As a result, relatively little of the benefit of the credit would go to reducing the ranks of the uninsured. Instead, a large share of the credit's substantial cost would go either to provide people who already are insured with another tax cut or to shift people from their current insurance arrangements (primarily through employer-sponsored coverage) to different insurance arrangements.

**Alternative: Tax Credits Targeted to Small Businesses for Providing Health Insurance**

According to the Kaiser Family Foundation survey of small businesses, among firms not offering coverage in 2001, 72 percent cited the lack of affordability as a "very important" reason for not providing health benefits (it was also the reason cited most often).

If one prefers to use a tax-based approach to the uninsured, one superior approach to help small businesses afford health insurance coverage for their workers would be to provide a subsidy directly to small businesses. The federal government could provide a tax credit to small businesses (say firms with fewer than 50 workers) offering health insurance benefits, with the value of the credit equaling a percentage of the employer's premium costs, say 50 percent. (The firm would not be able to "double-dip" and also claim the existing deduction for health insurance expenses). The credit would be available to both employers currently providing such coverage and to businesses not currently offering health benefits. According to the Kaiser Family Foundation survey, 89 percent of small business executives supported offering tax credits to employers to help them purchase health insurance for their employees.

To maintain a relatively modest cost and target the credit to the most vulnerable small businesses who are least able to offer coverage, the credit could be designed to provide the greatest subsidy to the smallest firms *and* the firms with substantial numbers of low-wage workers. Professor Jonathan Gruber of M.I.T. has suggested such a credit. While the credit would be available to all firms with fewer than 50 workers, the subsidy would be largest for the smallest firms (say firms with fewer than 10 workers or some higher level) with the value of the credit slowly phasing out by firm size. In addition, the credit would also be targeted at firms with many low-wage workers. The value of the credit would be largest for firms whose average wage is less than some annual earnings benchmark or hourly wage level, with the credit slowly phasing out above that level. (In other words, the credit would phase out along two dimensions: firm size and wage levels).

This design has the benefit of targeting the greatest subsidy to the small businesses that most need it but still providing at least some financial assistance to all small businesses with fewer than 50 workers. The slow phaseouts would also have the benefit of minimizing any adverse effects on firm behavior that could result from targeting the credit in this manner. For example, establishing such eligibility criteria for the credit could risk discouraging firm growth or higher wages for workers. For example, if the credit was fully available to a firm with 50 workers but not for a firm with 51 workers, the marginal cost of adding a 51$^{st}$ worker would be equal to the aggregate value of the full credit to the firm for all of its workers' health insurance premiums. As a result, the firm may be reluctant to hire more workers. A slow phaseout would be one way to reduce these disincentives significantly.

Most importantly, the credit would not disrupt — and would build on — the current employer-based health insurance system. It would assist firms currently offering traditional coverage (so that they can continue to afford such coverage) as well as encourage other (or new) firms to offer coverage for the first time. It would not produce the adverse selection risks resulting from MSAs and tax credits that could significantly increase premium costs for traditional group health insurance coverage. Such coverage is more affordable for older and sicker workers and provides comprehensive benefits. Substantial weakening of traditional group coverage would disproportionately affect older and sicker workers, leaving them either underinsured or uninsured.

Finally, according to the Kaiser Family Foundation survey, 61 percent of small business executives believe employees would be better off in employer-based coverage than on their own in the individual market and 74 percent thought it would be harder for employees in the individual market to meet their health insurance needs if they got sick than if they were in employer-based coverage. A tax credit to small businesses would meet these preferences.